THE RURAL COMMUNITY SERVICES NETWORK

FOR

BLIND AND VISUALLY HANDICAPPED PERSONS

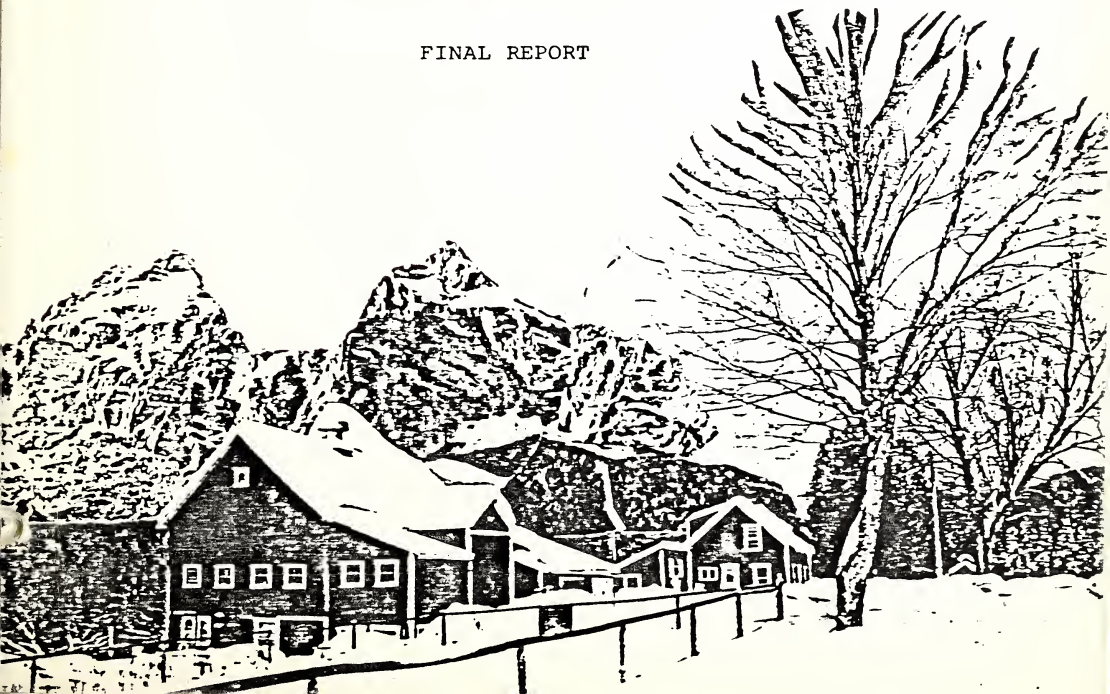
1978 - 1981

A PROJECT OF

THE NEW HAMPSHIRE ASSOCIATION FOR THE BLIND

LAMPLIGHTER PRODUCTS

FINAL REPORT



FINAL REPORT

OF

THE RURAL COMMUNITY SERVICES NETWORK PROJECT

FOR

BLIND AND VISUALLY HANDICAPPED ELDERLY PERSONS

1978 - 1981

A PROJECT OF

THE NEW HAMPSHIRE ASSOCIATION FOR THE BLIND

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RURAL COMMUNITY SERVICES NETWORK

Advisory Council

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* Pearl McMichael - Chairperson

- -

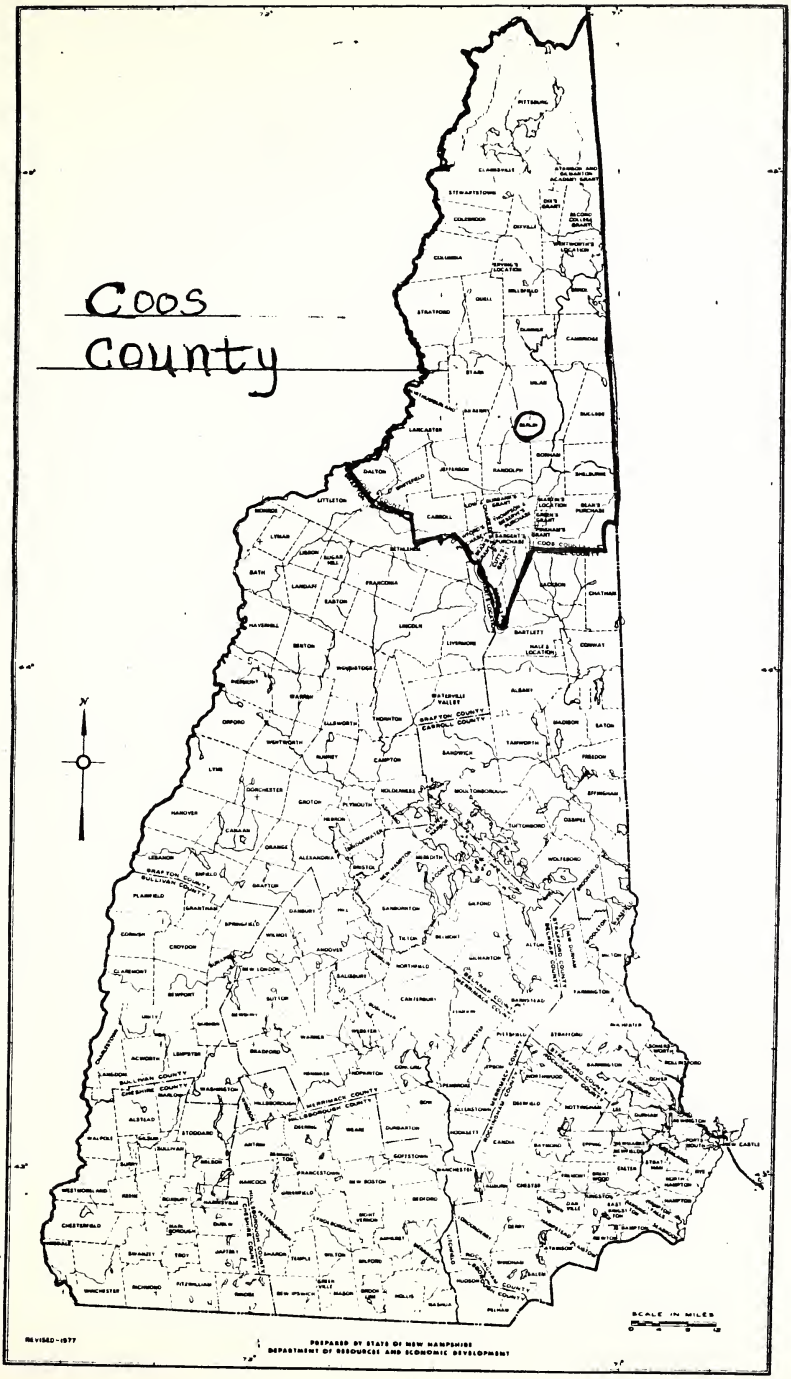
PAST

* Armand Breton
Alvin Carter
Roy Cascadden
* Florence Croteau
Joy Keddy
Lucien Lamoureaux
Paul Losier
Daniel Marois
* Melvin McKenna
Lorraine Merrow
* Charles Michaud
** Charles Zanes

* Mildred Linnell

* Visually impaired

** With visually impaired spouse or parent


Coos
County
COOS COUNTY
SCALE IN MILES
REVISED - 1977
PREPARED BY STATE OF NEW HAMPSHIRE
DEPARTMENT OF RESOURCES AND ECONOMIC DEVELOPMENT

Rural Community Services Network Project Findings
Have been Disseminated
Through the Following Organization

- -

American Association of Workers for the Blind
Association for Education of the Visually Handicapped
Northeast Chapter Regional Conference - Waterville Valley, New Hampshire
October 1979

Visual Impairment Service Team Conference
V.A. - Blind Rehabilitation Services
Cleveland, Ohio - July 1981

6th National Institute on Social Work
in Rural Areas
Frogmore, South Carolina - July 1981

*Seminar on Services to Older Blind
Rehabilitation Services Administration/Department of Education
Washington, D.C. - November 1981

* Note - A sample presentation outline and summary is included in the appendices.

TABLE OF CONTENTS

PURPOSE OF DOCUMENT

The purpose of this document is to chronicle the activities, processes, findings and recommendations of the demonstration project known as the Rural Community Services Network for Elderly Blind and Visually Handicapped Persons, herein referred to as "The Project."

The document is divided into sections which seek to describe the area in which these efforts took place, both geographically and culturally, to provide an historical background of some three years prior to the inauguration of The Project; to summarize the proposal which led to The Project's funding by RSA/Department of Education; and to outline some of the problems inherent in the delivery of social services in a rural community.

A number of activities will be described in detail. The rationale for, and processes of, conducting these activities will be discussed along with the findings resulting from them.

As a result of our observations we have formulated a number of admittedly subjective evaluations of the activity itself, and the processes involved in its conduct. (This process evaluation is in addition to the objective analysis and evaluation of services being provided by the *American Foundation for the Blind Research Department.)

From these observations and evaluations we have developed a number of recommendations regarding service delivery to elderly blind in rural areas which should be of value to other organizations in similar communities.

***Report is under separate cover.**

BACKGROUND

GEOGRAPHY AND COMMUNITY PROFILE

HISTORY

PROPOSAL SUMMARY

Geography and Community Profile ·

Coos County is the northernmost county in the state of New Hampshire. It is bounded on its eastern border by the state of Maine, on its western border by Vermont, and shares its northern border with the Province of Quebec, Canada. It is a small, relatively self-contained rural community commonly referred to as the "north country." Surrounded by the very beautiful White Mountains, Coos County is isolated from the more populous areas of central and southern New Hampshire by distance, weather, and the natural barrier of the Presidential Mountain Range. The county population of approximately 34,000 lies on 1,706 square miles of land, 95% of which is forest. It has 38 towns whose populations range from 262 to 3,401 with only one city, Berlin, having a population of approximately 13,000.

The city of Berlin has a pronounced cultural and ethnic flavor due to its 75% French Canadian, Roman Catholic population, many of whom are bilingual, and for whom French is the native language.

The county's single industry is its two paper mills and the logging operations which are attendant to it.

Other facts describe Coos County. Its average weekly income is the second lowest of the ten counties in New Hampshire while it ranks highest in its rate of both suicide and alcoholism. Of the state's elderly (65+), three percent live in Coos County and this three percent represents 18% of the total county population.

The area is postcard beautiful with its mountains and streams providing the backdrop for its small, picturesque New England towns and villages.

The Androscoggin Valley area of Coos County, which consists of five towns, with Berlin as its geographic, population and social center, is bound by the dominant religion and its French Canadian culture. It is

significantly influenced by a "live and let live," "suffer in silence" mind set; one which views stoicism and utter self-reliance as positive virtues and which suggests the seeking of help to be a sign of both personal failure and social weakness.

A native residence once described the entire county as "geographically isolated by chance and socially insulated by choice."

Here, then, resides a population socially and culturally committed to all those qualities that characterize that rugged individual known as the "New England Yankee." It is an especially difficult milieu in which to deliver services.

HISTORY

The need for a program was precipitated as the result of a public meeting held in the community on the topic of "Community Response to Aging and Blindness." This meeting was sponsored by the Association and funded through a grant from the New Hampshire Council for the Humanities.

As a result of this meeting, the New Hampshire Association for the Blind reordered its service delivery priorities for this community. Essentially this involved a substantially increased social casework and rehabilitation teaching service to this area.

In addition to her usual and customary work with individuals and families, the social worker observed the common need among clients for certain self-help skills and arranged, in cooperation with the association's rehabilitation teaching department, a series of structured group sessions covering a 10-week period and also involving meetings with clients' families and relatives present. A follow-up was then conducted by the teacher with clients at home as needed. This format was very well received and was repeated for an additional 10 weeks covering other skills for management and independence of function. (See Appendix)

As an unexpected spinoff of this type of group instruction, a consumer group has been established within the community calling itself the Northern Lites. The independence of this group in organizing and planning activities has been nurtured by the Association's caseworker, whose role has been primarily that of a group work facilitator. The formation of this consumer group has brought out good leadership qualities in several of the consumers and has been strongly supported by consumers themselves. Its activities which include a bowling league, day trips, business meetings, suppers, etc., seem to indicate a long standing, unmet need for socialization and peer support activities.

This group has also received some excellent media coverage including radio as well as newspaper, and has become highly visible within the community. This has been a positive experience in raising the consciousness level of the general public concerning the abilities of blind persons. It was determined that this group will be available to form the nucleus for a community advisory group.

The consumer group did a splendid job of organizing itself for this effort and raised $1,000. The Association's executive director and the regional consultant for the American Foundation for the Blind agreed that they would seek matching monies for the purpose of implementing this program.

Meetings were held within the professional community in an effort to assess levels of interest and support. These meetings were organized by the association with the able assistance of the regional representative of the American Foundation

for the Blind, and involved key representatives of local service agencies, civic organizations, and consumers.

SUMMARY

In view of the evidence indicating local community support, particularly among consumers, the Association felt it to be both timely and strategically opportune to establish the presence of a blindness system within the community at the earliest possible date, if its credibility as a state-wide service provider was to be preserved. It sought to act as a catalyst to other agencies both local and state-wide in actively seeking new and innovative service delivery to this hitherto isolated and underserved population.

NEW HAMPSHIRE ASSOCIATION FOR THE BLIND

60 School Street
Concord, N.H.

Rural Community Services Network for Elderly Blind and Visually Handicapped Persons

PROPOSAL SUMMARY

On May 25, 1977, a one-day meeting was held in the community of Berlin, New Hampshire, on the topic "Community Response to Aging and Blindness." This meeting was one of a series of four held in various communities throughout the state, made possible by a grant from the New Hampshire Council for the Humanities.

As a result, a unique opportunity exists in Berlin, New Hampshire, to engage in a follow-up demonstration or pilot project to organize local resources within the community to address the expressed needs of its elderly blind and visually impaired residents.

Objective:

To lead and assist a given community to mobilize its local resources in a cooperative and positive response to the expressed needs of its elderly blind and

visually impaired residents.

Purpose:

To demonstrate that the needs of this special population can be substantially met at the local level through the development of adequate supportive systems within a community.

Goals:

1. To sensitize local community resources to the role they can perform in assisting elderly blind persons to maintain independent life styles; and to serve as an advocate to encourage their integration as active, participating members of the community.

2. To stimulate local resources to join in developing and implementing a cooperative plan of action which will lend support and contribute to the ability of elderly blind persons to retain independence of function and achieve integrated status in community activities and affairs.

3. As a corollary activity: To develop at the local level an ongoing "Outreach" program or system to search out elderly blind and visually impaired persons in the community who may have need for services and to inform and encourage those who may be unaware or reticent to request same. Importance of this aspect should be emphasized.

Method:

1. Establish a small but effective Advisory Council of representatives of statewide agencies, consumers and other interested parties concerned with and about elderly blind persons--to provide direction and guidance for developing strategy and

for planning and carrying out a successful community organization effort to achieve desired goals.

2. Arrange or provide for utilizing the skills of a local person(s) knowledgeable in community organization techniques, geriatrics and the blindness field -- to work with various elements within the community under the general direction of the Advisory Council. This person(s) would serve as an advocate and work to effectively involve local resources in addressing the community's responsibility for providing adequate supportive systems for its blind and visually impaired senior residents.

Approach:

Recommend using as a base or point of reference the insights and knowledge gained from the recent meeting held in Berlin on the topic, "Community Response to Aging and Blindness".

Initial focus should be obtaining local support and commitment from the community's governmental structure, consumers and other appropriate groups to (1) more fully assess the existing and anticipated needs of its older blind and visually impaired residents, and (2) determine how the community can more fully utilize its resources in response to the needs of this minority segment of its population.

Target Community:

The greater Berlin, New Hampshire Community, will be the area for this follow-up demonstration since conditions within this community and the community itself, lend themselves well to this type of effort.

COMMUNITY ORGANIZATION

RURAL COMMUNITY SERVICES NETWORK

ADVISORY COUNCIL-WITH FINDINGS AND RECOMMENDATIONS

BLINDNESS/DIABETES SEMINAR-WITH FINDINGS AND RECOMMENDATIONS

ADVOCACY SEMINAR-WITH FINDINGS AND RECOMMENDATIONS

QUESTION AND ANSWER SESSIONS-WITH FINDINGS AND RECOMMENDATIONS

ESCORT SERVICE-WITH FINDINGS AND RECOMMENDATIONS

INTERGENERATIONAL PROJECT-WITH FINDINGS AND RECOMMENDATIONS

OPHTHAMOLOGICAL OUTREACH PILOT STUDY

GENERAL FINDINGS AND RECOMMENDATIONS

The stated objective of the RCSN Project proposal was "to lead and assist a given community to mobilize its local resources in a cooperative and positive response to the expressed needs of its blind and visually handicapped residents." It proposed to demonstrate that the needs of this special population could substantially be met at the local level through the development of adequate support systems within the community.

With these major goals in mind the Project was divided into three interlocking segments: social work services, community organization and research and evaluation.

Staffing

The services of a social worker were to be provided by a BSW whose responsibilities involved individual and family counselling, case planning and case management.

The community organization component was served by the Project Director and two Outreach workers. The Project secretary was bi-lingual. The supervisor of professional services in the agency's central office (the regional area social worker) furnished the liaison with that office.

Originally all staff were natives of the area; however after only six months the Project Director resigned and efforts to recruit one from within the geographic area were unsuccessful. Over two months were required to secure a replacement. (Recruiting qualified personnel for a geographically isolated rural area is a process which often takes longer than does that same process in an urban setting.)

The Community Organization Perspective

The community organization segment of the Project is the umbrella of both its direct service delivery and its outreach efforts.

It focused on three objectives. First, to identify the visually impaired elderly in the community and provide them with all of the services which would enhance their lives and add to, or sustain their efforts toward independent living.

Secondly, to educate and sensitize all of the people in the community about

blind people and about blindness as a phenomenon, so as to reduce stereotypical thinking and thereby effect attitude change.

Third, to inform other professional social service providers about blindness and blind people so as to enable them to respond more effectively to the referral needs of an individual. For example, a hospital dietician who is preparing a diet and diet instructions for an elderly person about to be discharged from a hospital needs to know if that person is print-handicapped. Perhaps the diet should be written in large print, or in braille. With this information a dietician is better able to assess the need for post-hospitalization follow-up instruction, or referral to a home-care agency for continued short term care. The process by which these objectives were met is called networking.

The principal methods used in this process were public education presentations and in-service training presentations. (See Appendix for a "Typical" public education presentation and Appendix for a listing of the kinds of organizations who received in-service training.)

The presentations, which were on-going throughout the Project, advocated the "case for blindness" to some 11,000 out of approximately 34,000 county residents.

Within this process linkages are formed which network clients into the county's human service delivery system. (See Appendix for a list of human service agencies in Coos County.) Originally, this networking process was envisioned as being somewhat more formal than the one which eventually evolved.

The education, informing and training of community groups, and other professional staff as well as special seminars for the health community also added links to the network chain. The presence of staff and Advisory Council members on other boards of directors and advisory boards served to strengthen those linkages. The education of elderly groups and club members served also to overcome a general reluctance to actively involve blind people in club activities and plans; further, it enabled members to encourage one another to seek either service or information about its availability.

The Project staff, aware of the often overwhelming paperwork involved in the delivery of services, made every effort to keep the referral process as simple as possible. Only two steps were required — the name, address and phone number of the client, and his clearly expressed willingness to be referred. This could be and often was, done by a telephone call to the office secretary.

It is, in our opinion, critical to the success of any networking effort that the staff of all agencies involved use their knowledge of service eligibility to provide information and referral for all persons as needed, regardless of eligibility for their own agency.

To that end, outreach workers and the staff social worker were familiar with the basic eligibility requirements of all agencies providing service to the aging population. In addition, staff had developed contact people within these agencies whose names were given to those persons requesting more specific information. Because these "connections" were not abused either by ignorance of eligibility or misinterpretation of agency policy, individuals were appropriately referred and the credibility of the outreach workers was firmly established.

For example: During visits to congregate meal sites an elderly person might be referred for help to the CAP weatherization and fuel assistance programs.

The effectiveness of the public education and in-service training activities is difficult to measure empirically, especially within the short span of this grant period. One might wish to examine the service statistics (see Appendix) as one indicator of effectiveness, but to do so, it is necessary to separate out (a) cases opened as community-based clients, from (b) cases opened as nursing home residents, particularly those opened in the third year through the Ophthalmological Screening Pilot Project (described later in this report). The distinction is important, because the sources of referral and the basis for opening a case were generally quite different in those two settings.

Concurrent with its direct service delivery, the Project initiated a number of special activities during its three years of operation. Each activity was designed to contribute in some way to the processes by which a community is informed, sensitized and educated to the needs, rights, and responsibilities of its members who are experiencing the multiple jeopardy of aging and blindness, as well as to enhance the processes by which clients are networked into the wider service system. Some activities continued for all three years and some were time bound for as little as three months. These activities were the Human Services Directory, Public Education Presentations, Advisory Council, Blindness/Diabetes Seminar, Wednesday Question and Answer Sessions, Escort Service, Intergenerational Project, and the Ophthalmological Project Pilot Study. Each activity is herein discussed as to process and product and is followed by a finding and recommendation.

SPECIAL ACTIVITIES

Human Services Directory

This involved the compilation, publication and distribution of a human services directory for the county. Until this time no comprehensive directory existed. Data regarding services was gathered by sending an information form to all the known agencies, and then by asking each of them who else they knew who provided a similar service or who else served a similar population, and to list those agencies to whom they referred clients.

This information was then checked by phone for accuracy. This process took approximately 6 months. Funds had been budgeted for the printing of this directory. Its publication was announced via newspaper and radio. Distribution of the directory was done by outreach staff as they traveled into various towns on other agency business.

Public Education

While ordinarily the method of seeking public education presentation sites was to send a simple letter introducing the Project and making the professional staff available (see Appendix for sample forms), some entrances were effected by more unique means.

Two examples come to mind. A male client, 65 and blind, had to have some lab work done at one of the local hospitals. A nurse handed him a piece of paper and a small plastic container. Since Mr. X could not see to read the instructions on the piece of paper he later told the social worker, "I didn't quite know what I was supposed to do with it!" Later on at a public education program for a Nursing Association, and with Mr. X's permission, this story was repeated. Very soon the administrator of this hospital contacted a number of known blind people in the city and asked them to tour the hospital and to indicate special areas of difficulty for those with vision problems. As it happened, Mr. X was a member of this group. Now the staff at the lab ask their patients, "Are the instructions clear to you?"

In an attempt to educate bank personnel, the outreach workers visited the bank in their own town and inquired about the method used for assisting people unable to see well enough to sign their checks. The teller explained that "we ask them to make an X". Tactfully, the outreach workers helped the teller to understand how offensive this is to the literate blind person and then demonstrated the proper use of signature guides, suggesting to the teller that the Association was available to help with any similar problems. The bank president later called the Project office and requested a public education presentation for his staff. This approach was repeated in many towns throughout the county.

During the second year of the Project, a unique outreach effort was accomplished. Outreach workers visited every parish pastor or rabbi in the county and requested permission to have a flyer explaining the services available included in the church bulletin. This resulted in the distribution of 5,000 pieces of literature about the Project and its goals. In part, because permission was requested by personal contact, it also resulted in some referrals for service from clergy.

During this same period 250 posters, listing the services of the agency and explaining how to acquire them, were placed in such diverse places as hospital and doctor's waiting rooms, general stores, barrooms, post offices, restaurants, social

service offices, social and fraternal clubs, grange halls, VFW, church meeting rooms, libraries and banks.

Advisory Council

In its first year the Project voluntarily designed an Advisory Council consisting of five consumers of service, five community representatives and five human service providers. The Council was designed along conventional lines and conducted regular monthly meetings with staff. Of its members who are visually impaired, all were also members of the consumer group known as the Northern Lites, which had emerged out of the early group meetings conducted by the original social worker prior to the Project.

Aside from the usual benefits of interpreting the community needs to the Project staff, this organization tended to foster grass root support, publicize service availability, and stimulate public education program invitations. The Council also served as a vehicle by which the Project was interpreted to the community, as well as acting as a source of client referrals. It also served as a forum from which leadership and advocacy skills could be developed and strengthened by the five members who were vision impaired.

At the end of Year II, this Council was significantly restructured into five separate town councils. This restructuring was proposed by staff but its implementation was voted on by the Council membership. Each town council consisted of at least one consumer, one community member and one service provider. These councils met monthly with staff in the town in which they lived and all five town councils met collectively every three months.

Finding #1

The traditional Advisory Council design has inherent problems, not the least of which is the tendency for the Council to be dominated by those members who live in the geographic area in which the meetings are held (in this case Berlin), thereby reducing county-wide representation. Citizens in more isolated towns in the county often express resentment that everything is centered in Berlin. It must be kept in mind however that the town of Pittsburgh, for example, in the northern portion of the county, is a one and one-half hour drive from Berlin and for six months of the year the driving to and from there is hazardous at best.

A usual solution is to hold meetings in different towns in the county each month, but our observation and in the opinion of the experts, this procedure serves only to fragment the group and reduce its effectiveness.

Recommendation #1

The town council concept, which this agency tested for one year, is more effective than the traditional design.

The Project used five councils (see Appendix for map of towns).

Benefits accruing from town council concept:

1) the dominance of a single, geographic area is eliminated.
2) wider community representation is possible.
3) travel costs are reduced since only one person needs to travel any distance.
4) New members, often most appropriate to the Council, are more able to serve. For example the directors* of two nursing homes were members of town councils, although neither would have been available to serve when meetings were held in Berlin.
5) council members, because they possess a more intimate understanding of the needs and resources of their own community are more productive.
6) referrals to specific individuals for specific kinds of public education and public relations activities are significantly increased, as is the identification of the natural helping network functioning in the community.

Finding #2

In a rural community people are often not sophisticated regarding voluntary boards and social service agencies. This is particularly so for the visually impaired members who have thus far had very little opportunity in the decision making bodies of the sighted community.

*Both nursing homes were ultimately used as sites of the Ophthalmological Pilot Study.

Recommendation #2

An agency must educate its Advisory Council members in the areas of rights and responsibilities of consumerism and self-advocacy and conduct seminars dealing with voluntary boards, their functioning purpose.

(See Appendix):

Advisory Council Description of General Functions

Advisory Council By-laws

Proposed Restructuring of Advisory Council

Map

Periodic reviews of the caseload by the supervising social worker failed to reveal the 30% - 50% of the statistically expected blind diabetics. In addition, all the available data indicated a lack of knowledge on the part of a significant portion of the health community about diabetes and its prdictable damage to vision, as well as a noticable failure to affect the entrance of the visually impaired diabetic any where along the contiuum of service in the health care system.

In response to this phenomemon, Project staff designed and implemented a series of seminars on blindness and diabetes for health and health related professionals. Four area physicians lectured on the pathophysiology of diabetes and current treatment modalities for diabetic retinopathy. Other topics treated were psychological/social implications of diabetes and blindness, along with demonstrations of devices currently available to the visually impaired diabetic. A reactor panel representing varying disciplines completed the seminars.

FINDING

All too often people were seeking medical care at the point in their diabetes when the presenting problem was already a disruption of vision!

RECOMMENDATION

Efforts to educate diabetics about their disease should be supported. For example: hospital or nursing home in-service coordinators should conduct training sessions for in-house patients.

FINDING

The seminars acted as a catalyst for a nurse practicioner and served to develope and strengthen her thus far, unproductive attempts at educating health care providers, including physicians, in the Northern regions of the county and thereby, encourage referrals to the Project where ever appropriate.

RECOMMENDATION

Rural area service delivery is often practiced in isolation and requires a generalist approach. When ever possible, support, guidance and encouragement should be made available to the collaborating service provider.

FINDING

1. The health community is generally not knowledgable about diabetes and its effects on vision and since vision loss among diabetics is a long and tortuous process the medical community must be made aware that some help is both possible and advisable before blindness is an accomplished fact.

2. Methods for identifying the vision impaired patient in nursing homes and hospitals is frequently poor.

RECOMMENDATION

1. Other mechanisms, similar to our seminars on blindness and diabetes, should be developed which will insure that the medical community is continually educated regarding the latest treatment modes for diabetes.

2. Materials on the subject should be included in curriculum of home health aides, licensed practical nursing programs, health occupation classes in high schools and the like.

ADVOCACY SEMINAR

In mid April of 1980 the Project conducted a seminar which was designed to familiarize participants with the various aspects of both advocacy and consumerism.

Participants were the current members of the Advisory Council. Presenters were Mr. William Gallagher, then associate Director of Advocacy at the American Foundation for the Blind and Mr. Morton Kleinman, then the American Foundation for the Blind regional consultant to the New Hampshire Association for the Blind. Efforts were directed at clarifying the role of the consumer relative to the agency, as well as fostering a more thorough understanding of the most effective ways in which council members could contribute to the success of the Project's goals and act as advocates for blind people at both the local and state level.

Finding

Advocacy and consumerism are often in need of definition and a shared understanding of what is involved in each is necessary.

Recommendation

Education and training of Advisory Council members should be an on-going activity.

Wednesday Question and Answer Sessions

At the suggestion of a Council member, the Project social worker and one outreach worker designed a series of question and answer sessions to be conducted each Wednesday in a pre-selected number of towns.

The month of August was chosen and two sessions were scheduled — one in the morning and one in the afternoon in eight different towns — community meal sites or town halls were chosen. (See attached news release.) The meetings were intended only to provide general information about the Project and the Association and to enable people to meet the social worker and outreach workers in person.

Funding

Response to this effort was disappointing, probably due to the time of year (August) and to an insufficient amount of PR.

Recommendation

This form of public information should be tried, but during early fall or spring and for a much longer period of time.

PLEASE PRINT WEEKLY UNTIL AUGUST 27th!!!!!!!

July 28, 1980

FROM: THE NEW HAMPSHIRE ASSOCIATION FOR THE BLIND
101 NORWAY STREET
BERLIN, NEW HAMPSHIRE 03570

FOR IMMEDIATE RELEASE FOR IMMEDIATE RELEASE FOR IMMEDIATE RELEASE

IF YOU, OF SOMEONE YOU KNOW IS HAVING PROBLEMS WITH THEIR VISION, MR. RUSSELL K. LANDRY, A SOCIAL WORKER WITH THE NEW HAMPSHIRE ASSOCIATION FOR THE BLIND, BERLIN BRANCH OFFICE, WILL BE AVAILABLE TO ANSWER YOUR QUESTIONS. MR. LANDRY WILL BE AVAILABLE AT THE FOLLOWING LOCATIONS ON THE DATES & TIMES LISTED:

RINT NLY UG. 6th!	DATE: AUGUST 6th	DATE: AUGUST 6th
	TIME: 8:30 - 12:00 noon	TIME: 1:00 - 3:30 p.m.
	PLACE: WHITEFIELD SENIOR CENTER WHITEFIELD, NH	PLACE: TWIN MOUNTAIN TOWN HALL TWIN MOUNTAIN, NH
RINT NLY UG. 13th!	DATE: AUGUST 13th	DATE: AUGUST 13th
	TIME: 8:30 - 12:00 noon	TIME: 1:00 - 3:30 p.m.
	PLACE: COLEBROOK IOOF HALL COLEBROOK, NH	PLACE: NORTH STRATFORD SENIOR MEAL SITE NORTH STRATFORD, NH
RINT NLY UG. 20th!	DATE: AUGUST 20th	DATE: AUGUST 20th
	TIME: 8:30 - 12:00 noon	TIME: 1:00 - 3:30 p.m.
	PLACE: LANCASTER TOWN HALL LANCASTER, NH	PLACE: DALTON TOWN HALL DALTON, NH
RINT NLY UG. 27th!	DATE: AUGUST 27th	DATE: AUGUST 27th
	TIME: 8:30 - 12:00 noon	TIME: 1:00 - 3:30 p.m.
	PLACE: GORHAM TOWN HALL GORHAM, NH	PLACE: JEFFERSON TOWN HALL JEFFERSON, NH

Escort Service

As an outgrowth of its examination of possible roles for volunteers, staff members and advisory council members proposed that the Project consider testing the feasibility of an escort service. It was decided in July of 1980 to use Project outreach workers to pre-test the idea in order to determine the time involved, the training needs for the volunteer, and the supervision required. The plan was then to evaluate the cost and benefits of the service. The idea in using staff at first was to pre-test it before involving volunteers.

The area does have limited portal to portal transportation operated by CAP, though it does not provide assistance with shopping, doctors appointments, etc. — only transportation to the store or office as the case may be.

The Project social worker polled the clients in an effort to discover the level of need for, and interest in, a personal escort service. While there had been much talk about how much it was needed, the actual number of clients willing to use such a service was small. Only four clients expressed an interest and of these four, two were a married, elderly couple who are both totally blind.

The escort service was provided by the outreach workers for the last year of the Project and is, as of this writing, being handed over to a volunteer referred for this effort through RSVP.

Finding

The Project staff thought that the mutual responsibilities and services of the escort services were adequately understood by both parties, however services were not clearly defined, and in consequence misunderstandings occurred. Problem areas: what constitutes "shopping" -- all errands?, essential things only, such as doctors appointments, food shopping only?

Recommendation #1

A clear and very specific written, definitive memo of understanding should be entered into and shared. For example: escort service for name will be provided for grocery shopping on alternate Tuesdays from 9 - 12 for a six month period at which time service need is to be re-evaluated.

Recommendation #2

A dual evaluation at the end of the sixth month, which is shared, should be conducted in order to correct any difficulties.

Recommendation #3

As with any volunteer effort, the total length of time of the volunteer commitment should be established ahead of time.

In October of 1979, a program funded by the New England Center for Social Intervention of the University of New Hampshire funded under Title I,, Education Act, conducted a series of meetings in collaboration with the Coos County Co-operative Extension and the local 4-H Programs entitled "Sensitizing Communities to the Needs of the Elderly." These meetings, to which a staff outreach worker was assigned, developed a time framed (12 weeks) program which sought to match elderly people with young people in an effort to address two problems: the social isolation of many area old people, and secondly, the lack of contact and interaction with aged persons being experienced by our young people. The program hoped to bridge that intergenerational gap and be of a benefit both to young and old alike. (The area does not have a foster grandparent program which would supply similar kinds of benefits.)

The Project agreed to participate and begin to plan training programs for those young people who would be working with visually impaired people. At the same time the social worker surveyed the caseload and called any whom he thought might be interested. A number of benefits appeared possible. Readers might be found through this mechanism and thereby overcome the difficulty of getting volunteers for this task (a perennial problem in the county, especially in the greater Berlin area) and the general goals of the program could be met.

By February of 1980 five 4-H children were trained by Project staff and were matched with six visually impaired clients. One is a couple (both of whom are blind). Matching of clients to 4-H children was done on consultation with the social worker and introductions were made by outreach workers.

Findings

Too much time had elapsed between first contact of clients and actual implementation (October to February) during which client interest began to flag.

Supervision responsibility of the placement was not clearly defined early enough. Geographic areas were not pre-determined and so clients wishing to participate often were in areas in which no 4-H program existed.

The outreach worker found herself doing activities which should have been done

by the program initiators.

Recommendation

Collaborative efforts which are by definition short term, as in this case, require definitive and very specific agreements as to who is responsible for what and when.

NOTE: This same organization requested the Project's collaboration in another program later in the year. Project staff agreed to join the effort as soon as its goals, objectives, and processes were clearly defined. Nothing happened.

*OPHTHALMOLOGICAL OUTREACH PILOT STUDY

The Ophthalmological Outreach Pilot Study was a four day project undertaken in April at Morrison Nursing Home in Whitefield and in June at the Country Village Health Care Center in Lancaster. It was felt that there were a large number of elderly, visually impaired adults residing in the area nursing homes that were unable to obtain recent ophthalmological treatment due to the distances involved and the physical limitations of the patients themselves. The project proposed to alleviate this problem by engaging the services of an area ophthalmologist and optometrist to conduct in-house examinations using equipment available in NHAB's low vision van.

The first activity of the project was to conduct a survey of local ophthalmologists and optometrists to see if any were presently doing home visits. It was found that of the eye specialists in the area that one was presently doing home visits. Since the New Hampshire Association for the Blind has a staff optometrist and since she was familiar with the van and its equipment, it was only necessary to engage the services of an ophthalmologist currently serving the Coos County area, only one showed any real interest in the project. Dr. Foord, a Berlin based ophthalmologist, was ultimately chosen and a formal letter of agreement was signed prior to the actual examination of nursing home residents.

*see appendix for proposal

The Project Social Worker spent many hours in the nursing homes before the eye examinations to be sure of making the best possible use of the ophthalmologist's and optometrist's time. The social worker felt that the three main preliminary activities could be categorized as administrative, procedural, and the creation of an atmosphere of enthusiastic co-operation.

Enthusiastic co-operation proved to be the most critical factor in the outcome of the project. This enthusiasm must be genuine and include project team members, nursing home administration and staff, and ultimately those nursing home residents to be examined. The project was first thoroughly explained to the nursing home administration. It is beneficial to emphasize the importance of yearly eye examinations for elderly citizens. This helps the nursing home staff to realize that the projects' intentions are to augment total patient care rather than point out deficiencies in that care. Enthusiasm can also be created by getting as much of the staff included as possible. This enables the staff to see themselves as part of the project and as having a responsibility for its outcome.

The nursing home social worker can be utilized in helping to prepare patient histories, the head nurse can give insight as to medical conditions that may affect eye care and the nurse's aides can be used to help transport patients to and from the eye examination room.

In nursing home one an excellent atmosphere of enthusiastic co-operation was established using the methods indicated above. This resulted in a very smoothly run clinic, in which both patients and staff were satisfied with the outcome. In nursing home two this atmosphere of enthusiastic co-operation was never fully established. The end result was that the nursing home residents got the impression that they were being forced to have their eyes examined and the motivation required to participate in an eye examination was absent. It was felt that part of the reason for this lack of co-operation was due to a recent move to a new building. The confusion and anxieties of this move seemed to relegate the ophthalmological pilot project as one more "nuisance" to be encountered before the nursing home staff and residents could settle down to a more comfortable daily routine.

The administrative aspects of the project were simply a matter of understanding what was to be done and who was to do it. Again, the project social worker tried to involve as much of the nursing home personnel as possible. After getting permission to undertake each project from the administrators of the respective homes, meetings were set up with nursing home social workers. The project was again fully explained, and co-operation was solicited from the nursing home social worker. All this time the nursing home social worker was asked to provide basic information such as name, date of birth, and social security number of each resident. A more complete intake was to be done on each patient at a later date by the project social worker. The administrative activities between the project

social worker and the ophthalmologists and optometrists were pretty much spelled out in the grant. A formal letter of agreement was signed before the initiation of the doctor's services. This letter spelled out billing procedures and what was expected from the parties involved.

The procedural aspects of the project were the most difficult and time consuming. They could roughly be narrowed down to what the project social worker must do and what the doctors must do. The examination procedure was worked out between the ophthalmologist and optometrist a half hour before the actual examination. It was decided that the optometrist would first examine each resident. At that time spectacles were objectively measured and visual acuity both near and far was tested. The project optometrist also tested depth perception and color vision and accurate records for each resident were maintained. The resident would next move to an adjacent room where ophthalmological equipment was stationed. The ophthalmologist then did the medical aspects of the exam and again proper records were maintained. It was found that the optometrist would continually be ahead of the ophthalmologist and this often resulted in an extended waiting period for residents where ideally waiting periods for the elderly should be kept to a minimum. The project social worker has no other solution to this problem other than scheduling residents as thoughtfully as possible.

It was the scheduling of patients that took up the bulk of the project social worker's time prior to examinations. The social worker felt it necessary to interview each nursing home resident.

This interview was designed to ascertain each patient's visual level and need and also to get a feel for each resident's ability to withstand a prolonged eye examination. The project was explained to each resident and they they were asked when they had their last eye examination. Responses varied from "3 weeks ago" to "so long ago I can't remember." Interestingly enough the project social worker found that almost half of the respondents who remembered getting eye examinations named local optometrists as having provided the treatment. The social worker also asked each resident if they had relatives in the immediate area. This question was included in the event that the ophthalmologist found any serious eye problems that the family would want to know about. The project social worker also asked each resident how long they had been living at the nursing home. This question proved to be an excellent proble of long term and short term memory loss and was an effective measure of a resident's mental capacity to be an active participant in the ophthalmological examination. Questions regarding health, hobbies, interests, and past experiences helped the social worker get a feel for the resident as a whole person. The social worker tried to interview 5-6 residents a day for 30-45 minutes per person. This resulted in repeated visits to the nursing homes involved and served to generate staff and resident enthusiasm for the project. After the interview the social worker coded each resident as to the estimated ease of the ophthalmological examination. Considerations in assigning code numbers were mental alertness, physical and mobility problems, and degree of motivation towards having an eye examination. Several residents did not want their eyes examined and their wishes were respected. These code numbers

became the vehicle by which the social worker arrived at a reasonable appointment schedule. Since it was felt that the extent of the examination was dependent on the ability of the residents, people of similar mental and physical capacities were scheduled to be seen in clusters. People in wheelchairs were also scheduled together because the examination equipment had to be modified slightly to accomodate wheelchairs. People were scheduled at the rate of 3-4 per hour up to about 25 examinations per day and this proved to work out quite well. The project social worker provided the nursing home administration and staff with copies of the appointment schedules three days in advance. This was seen as necessary because a project of this size is a considerable disruption in the home's every day activities. It allowed the staff and resident to be ready to alter their daily routine to be on time for their eye examination. It also helped lessen the amount of time spent in the waiting room.

RESULTS

On April 15th and 16th of 1981, 47 patients were seen at the Morrison Nursing Home in Whitefield, New Hampshire. Each nursing home resident received a complete ophthalmological examination and complete records were kept. The examinations lasted approximately fifteen to twenty minutes per resident. The average age was 84, and the range of ages of patients seen was 70 to 98. Three prescriptions for spectacle changes were given as were two medical prescriptions for eye infection.

The study uncovered one case of uncontrolled glaucoma and four cases of cataracts that warranted immediate extraction. There

were eleven additional cases of cataracts that may need attention in the future. Four people were found to have macular degeneration. As a result of this study six people were found to be legally blind and they were referred to the state for possible low vision services. In all cases residents were given an explanation fo their eye condition and a plan for follow-up action.

On June 3rd and 4th of 1981, 37 patients were seen at the County Village Health Care Center in Lancaster, New Hampshire. Each nursing home resident received a complete ophthalmological examination and complete records were kept. The examinations lasted fifteen to twenty minuted per resident. The average resident age was 79. The mean age was 82 and the range of ages was 32 - 100.*

This study uncovered three cases of cataracts that seemed to require immediate extraction. Seven cases of cataracts were seen that may need future attention. Two medical perscriptions for eye infections were given and four prescriptions for spectacle changes were given. One person was found to be legally blind and six people were recommended for low vision. In all cases residents were given an explanation of their condition and a recommendation for follow-up action.

* Two residents under the age of 55 were examined.

RECOMMENDATION

The New Hampshire Association for the Blind feels that it is important for elderly citizens to receive eye care on a regular basis. We believe that this "outreach" was worthwhile in terms of the direct care provided to these particular patients, as well as helping us to assess the degree of unmet need that may exist in similar settings.

SERVICE DELIVERY

PROBLEMS OF RURAL SERVICE DELIVERY

IMPROVEMENTS IN SERVICE DELIVERY

A CASE OF TWO BROTHERS

NORTHERN LITES-BACKGROUND AND ANALYSIS

ADDENDA-PERSPECTIVES I AND II

General Findings and Recommendations

Re: Public Education

I. An initial concern of the outreach workers, both of whom are para-professionals, was that health service professionals, hospital nurses for example, would be so sophisticated in their knowledge levels about vision and eye diseases that professional staff would be needed to answer questions at any in-service training for a professional health agency. In actual fact it was discovered that, regardless of educational levels, understanding of blindness and blind persons is minimal at best, so presentation styles were adjusted for the educational level of the audience, but content remained constant.

Re: Human Services Directory

II. As a result of the compilation and publication of a human services directory the image of the area as suffering from a poverty of service had to be adjusted, as the county contained 119 providers of service — some 35 of whom serve the elderly population! These data offered support for the Association's tentative position that area services were under-utilized rather than non-existent.

Re: Referrals from Ophthalmologist

III. Traditionally, ophthalmologists do not refer their patients to agencies serving the blind. It has been postulated that the physician, so thoroughly committed to healing, cannot cope with the fact that despite his best medical efforts his patient's vision will continue to worsen, and to refer that patient to an organization serving blind people is seen by that doctor as an admission of his own failure as a healer. In response to this phenomenon, the Project sought to educate and sensitize the secretaries working in the office of the county's one ophthalmologist. At this time the referral rate from this doctor to the agency is 20-30% of the total caseload.

Re: Staffing

IV. It is most effective to employ staff who are native to the area, and do not behave in ways which are contrary to accepted community mores.

Re: Public Education

V. Information regarding blindness and preventative eye care should be included at the appropriate grade level (usually grade 5), when children study the life of Helen Keller. In addition, suitable materials can be included in the curriculum of high school health occupation classes, in homemaker/home health aide training and licensed practical nursing programs.

VI. Local radio should be used extensively for public service announcements as well as for interview-type programs. The use of this media is especially important when serving a print-handicapped population. In a bi-lingual community both languages should be used whenever possible.

VII. Rural communities have special celebration days (in our area called Old Home Days) and every opportunity should be taken to participate in some appropriate way in these celebrations.

VIII. Clinics and health screenings generally abound in a rural area and these provide opportunities to meet and work collaboratively with other providers of service. Outreach workers should attend all such screenings with either informational material or to perform a service, such as conducting a vision screening.

IX. To do successful outreach in a rural setting is to be cognizant of the fact that often the relationship must come before the task.

*PROBLEMS OF SERVICE DELIVERY IN RURAL AREAS

There is general agreement that rural America has the same range of social problems, and the same needs for social services as those found in American cities. The need for social services correlates most directly with the degreee of poverty in an area. Anti-poverty researchers and other investigators have identified that poverty exists to an equal or greater extent in rural settings. In rural America, we find poverty comprised of depressed income, dependency, lack of opportunity, coupled with unique isolation, disproportionate representation of elderly poor, and insufficient social services. Social services that exist are difficult to administer efficiently, and are even more difficult for people to assess for reasons of the ever-increasing cost and inadequacy of transportation for both client and worker.

PROBLEMS FACING RURAL HUMAN SERVICE WORKERS

The rural setting provides the human service worker with a unique, difficult and complex environment within which to work. Among the problems faced by workers is the problem of service delivery logistics. Stated most simply, the problem is how to get the worker to the client, or how to get the client to the worker. In county, or multi-county wide programs this is a major dilemma.

Workers identify needs for referral services -- services or specialties that often do not exist within a 75 or 100 mile radius from the client. To obtain these services a worker needs to be knowledgeable about services that are some distance away, know people who will see that the client will get the appropriate service, and be resourceful in arranging transportation -- often through cooperating agencies. To be able to do this requires more time than is immediately apparent, and to accomplish this requires real skill and ability in networking.

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*Expectations Vs Reality in Rural Social Service Delivery, Davis & Fiskell, 6th National Institute on Social Work in Rural Areas, So. Carolina, July 1981

Further complicating the life of the rural human service worker is the lack of educational opportunities as a means of career advancement. Such opportunities seldom exist. This is further frustrating in that he or she is often called upon to provide services in matters that urban counterparts could readily refer to others, thus requiring a broader definition of the professional role with minimal opportunity to acquire the necessary additional expertise.

RECENT HISTORY

These facts have been true for many years. However, developments and new programs generated over the past fifteen years have presented new challenges to human service employees working in a rural setting. Programs begun in the mid-sixties were designed to have effects beyond those ever envisioned heretofore in social service legislation. Characteristics of the Great Society programs of the sixties were:

1) Programs had a process orientation.

2) Programs had a participatory theme.

3) Programs had an institutional change focus.

This was true of the early programs in Community Action, Headstart and other anti-poverty initiatives. And despite more conservative trends in the 1970's, legislation generated during this period such as programs for the elderly, alcohol and drug abuse programs, and even Title XX of the Social Security Act of 1974 have retained all or some part of these characteristics.

In small town rural America, the effects of federal grant-in-aid human service programs have been different and less clear. With some exceptions programs in the sixties and early seventies were designed to alleviate urban problems. Nonetheless, for reasons of equity and politics, programs were mounted in both rural and urban jurisdictions. The results were sometimes humorous.*

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*Headstart grantees in rural America often received budget amendments directing them to use public transportation. Public transportation, of course, does not exist in rural America.

While anti-poverty warriors were trained to advocate to city hall, rural America town government had relatively little control over sought-after resources. It is seldom noted, but the greater the rural characteristics of a state, the greater the amount of state control over essential services.

Rural Selectmen, who have basic authority for small town services, were bewildered by the infusion of money for purposes that not only were not clear to them, but may initially not have been clear to grantees and grantors. Further, insufficient emphasis has been given to the fact that programs designed to place poor people on community boards, and in controlling situations, challenged three hundred years of Calvinist traditions. This is, and was, especially true in rural New England.

An understanding of the reactions of small town leadership to the many programs and the vast amounts of federal resources coming into their communities in a manner over which they had no control is important in gaining an appreciation of the work environment of rural human service workers. Since the inception of the changing inter-governmental dynamics, small town fathers have become confused over the roles and responsibilities among the various programs. Small town leadership was, and is, understandably jealous of the new resources while working against a limited property tax base for basic town services. The absence of a logical and organized system of service delivery is highly visible in rural settings, and the federal logic for perpetuating categorization eludes rural leadership entirely. Explaining congressional committee jurisdiction, HEW turf warfare, and constituency politics to hard working small town leadership is a futile and thankless task.

The preceding describes the forces at work and the changes that have occured in the past 15 years that have impacted upon the work setting of the rural human services worker. These pressures have had effects not only upon traditional community institutions, and general purpose government, but have influenced the nature of the work itself.

Whether one is a social worker, rehabilitation counselor, child development specialist, public health nurse, or any number of others, there has emerged a more obvious generalist dimension in carrying out their jobs than was true twenty years ago.

As noted earlier, most programs begun in the past fifteen years have new dimensions relating to process, participation, and institutional change. Professionals working in rural programs are expected to understand and carry out roles relating to these new factors. In urban settings, programs may be sizable enough for personnel to be hired to carry out these specialized roles. In a rural setting professionals must carry out traditional roles for which they are trained, but also have to undertake community organization activities, including organizing program participants, advocating for their programs, as well as engaging in efforts in coordination and networking. In addition, the positions of executive leadership in small rural agencies are usually effected through the hiring of direct service workers into management positions.

The knowledge and skills that will be necessary include knowledge of community organization, community development, management, working in a hostile environment, working in the political dimension, dealing with inter-organizational complexity, handling community conflict, and networking, to name a few. In addition, professional insulation is lost, and the worker must know how to live with ambiguity, and to deal with conflicts that may develop between individual and group purposes.

Improvements in Service Delivery

The year 1979-1980 saw a greater awareness of the availability of rehabilitative programs for the visually impaired and an improvement in the service delivery system. Empirical evidence of this can be seen in the increase in referral rates over the last several years. (See appendix) A number of factors contributed to this improvement. Inherent to the development of a service delivery system is the personal relationships that grow through time with other service providers and referral agencies. These personal relationships improve the service delivery system as referrals can be handled faster and more economically. A locally based worker is better informed as to community events and issues and is perceived as being concerned with building his/her own community. The locally based worker is not only seen as more credible with other service providers, he is afforded more trust with the client as well. Often the immediacy of needs dictate that a client or potential client will seek help from the source quickest able to respond. The continuity of the same social worker over the duration of the project contributes to service delivery in the building of a natural networking system. Referring agents are more inclined to call upon a service provider they know and can deal with on a friendly basis. This personal relationship insures that red tape will be kept to a minimum and that needs will be addressed as quickly as possible. A final point on the importance of good personal relationships locally is that in isolated areas such as the North Country, there are strong feel-

ings of self and community sufficiency. The locally based worker is seen as a concerned community member rather than an impartial outsider. This can only help improve natural networking and the service delivery system.

Another factor necessary to improving the service delivery system is the building of a good working relationship with the Vocational Rehabilitation (VR) Counselor. This is especially true since the VR Counselor for this area is based 120 miles away. A service provider located this far must logically have a liaison to facilitate his rehabilitative process. The Rural Community Service Network Social Worker has become that liason. The social worker has familiarized himself with VR objectives and the forms necessary to meet those objectives. This familiarity creates an increasing professional collaboration with the social worker and results in better and faster service for the client.

A final factor that contributed to improved service delivery was the expanded community awareness about blindness created by outreach activities and publicity releases. There can be no service delivery unless the target population is aware of the availability of help. An example of this would be in the newly established *low vision program. Publicity releases resulted in a number of self-referrals interested in low vision evaluations. The following examples demonstrate the effectiveness of the R.C.S.N. and the social worker's role in case management and in building relationships with other service agencies.

* see Appendix for program description

The first example is that of a ninety year old, legally blind man and his eighty-seven year old, visually impaired, diabetic wife. Mr.& Mrs. X lived independently in their own home with the help of a homemaker provided by the local welfare office. Mr. X managed to do most of the household chores such as cleaning and cooking. He had difficulty in the areas of reading his bills and administering his wife's insulin injections. Mr. X was referred to the R.C.S.N. by Dr. Wm. D. Foord, a local ophthalmologist, for help in overcoming these problems. The R.C.S.N. social worker was responsible for the initial contact with Mr. & Mrs. X. At this time a needs assessment was done, and a mutually agreed upon caseplan was set into action. Mr. X initially stated that he would be interested in the state property tax exemption for the blind. He also expressed an interest in a low vision examination if it was to be done reasonably near his home.

His age and health dictated that the examination be done locally. The first step was to secure the appropriate releases for eye and medical reports. The social worker explained the necessity of obtaining these reports and assured Mr. X that they would be used to determine eligibility only and would otherwise be kept confidential. Once it was established that Mr. X was indeed legally blind, the social worker then registered him with the State making him eligible for the property tax exemption. At this point it became necessary to look for funding for rehabilitative training and a low vision evaluation. Mr. X was

considered to be a good low vision candidate because he had residual vision and the physical and mental capacities to undergo the examination. He was also well motivated and willing to work hard to accomplish several specific tasks. The social worker is a key person in the success of the low vision program. He must be sure the candidate fully understands the possibilities and limitations of low vision training. Understanding the possibilities is necessary to maintain a client's interest and motivation. Understanding the limitations is crucial so that the client does not become disapointed, ruining his trust in the social worker and the possibility of any further rehabilitative training. Since Mr. X was taking care of himself and his wife, the social worker looked for financial help form the VR Counselor with a vocational goal of homemaker. This is noteworthy considering Mr. X's age and the traditional stereotype of homemakers being women. The social worker made his case with the VR Counselor and the funding was secured, further demonstrating the desirability of good professional relationships in a service delivery system. The VR Counselor then sent the RCSN social worker his intake forms and asked that they be completed. Again, had the social worker not been familiar with VR objectives and paperwork, these necessary forms could not have been completed as quickly.

Mr. X was accepted for service and had a successful low vision examination. Much to his delight he was given aids that enabled him to read his own bills, see his clock, and more safely

administer his wife's insulin. He was then evaluated for both mobility and rehabilitation training. The mobility training consisted mainly of in-home orientation and was quite brief because of his needs, age, and health. The rehabilitation training helped him with home management and cooking. Interestingly enough despite the number of people who worked with Mr. X he understood the social worker to be responsible for his case plan and follow-up. He continued to periodically telephone the RCSN office with messages for the social worker until his wife passed away and he moved to live with relatives.

An example of a low vision client with different needs would be that of Mrs. Y. Mrs. Y was referred to the social worker by a member of the Northern Lites, a group of visually impaired consumers. Mrs. Y runs a summer restaurant and cabin business. When the social worker first met with Mrs. Y, she was contemplating selling her business on the assumption that her visual impairment would make it impossible to maintain her same level of activity. She felt that she could no longer see well enough to run the restaurant and clean the cabins. With the help of the VR Counselor, the social worker convinced Mrs. Y to accept rehabilitative training. The social worker and VR Counselor arranged for her to undergo a low vision evaluation even before the program was formally started. Mrs. Y was considered to be an excellent low vision candidate because she was very motivated and had the physical and mental capacities to work hard towards specific goals. In the case of Mrs. Y, the social worker se-

cured her property tax exemption and made the necessary rehabilitation teaching referrals (RT). RT was especially successful for Mrs. Y as she was eventually able to stay in business.

Mr. Z was a self-referral as a result of local publicity about the Berlin Branch-Office of the New Hampshire Association for the Blind. Mr. Z is a ninety-year old male whose family asked the social worker to visit to discuss his failing vision. The family was concerned that Mr. Z would go totally blind leaving them with a considerable hardship and draining them financially. They were also worried that if he became totally blind, that no nursing home would accept him. The social worker was able to alleviate some of the family's anxiety by assuring them that the chances of his going totally blind with his condition (macular degeneration) were slight. Nursing home regulations were explained and the family was referred to Legal Aid in the event of any problems. Mr. Z was also given a low vision examination although the prognosis was considered poor due to his advanced age and mental and physical deterioration. The examination revealed nothing in the way of aids that could help Mr. Z. He was not referred for rehabilitative training with his age and physical status again being the determining factor. The social worker felt that a definite service was performed for Mr. Z and his family. Their anxieties concerning blindness and the future were somewhat alleviated and they were secure in the knowledge that every possible avenue of hope had been explored.

A final and somewhat different example would be that of Mrs. Q. Mrs. Q is a ninety-year old diabetic, double-amputee living in a community with her daughter. She was referred to the social worker through the activities of the outreach workers at a Senior meals site. Despite her age and health, Mrs. Q is very alert and content with her life. She was definitely not interested in a low vision evaluation or rehabilitative training and the social worker respected her wishes. Mrs. Q enjoys crocheting and does it well. She was referred to the Home Craft Department of the New Hampshire Association for the Blind. Follow-up with Mrs. Q at this time consists primarily of friendly visits.

The above cases are intended to show the diversity of needs of the elderly blind population. They show the effectiveness of outreach by quoting a number of different referral sources. They show the effectiveness of service delivery by quoting the ability to quickly involve key agencies in the case plan. It is hoped that the above cases will show the necessity of having a local agent to respond to the needs of the elderly visually impaired.

A CASE OF TWO BROTHERS

What follows is a real situation used as a case study by the Project outreach workers as a part of a training session presented to Community Action Energy Outreach Program staff. It is, by the very nature of its overwhelming problems and expressions of profound deprivation, certainly not typical of country living, but rather was used to challenge the skills and imagination of the trainees.

Its inclusion here is an attempt to demonstrate the processes by which Project outreach workers linked these particular individuals into the county's helping network, both formal and informal.

Case Study #5

Two bachelor brothers living together, ages 71 and 69 respectively. They own a family farm of 400 acres, one half of which is tillable. Their house was built in 1850 as a 10 room home, and there is one room left standing. They have electricity but no plumbing. They are not willing to have anyone in their home that seems to be from the government. It must be a long time friend. No income except from raising and selling livestock. As stated before, house is in deplorable condition, cat sleeps in frying pan on wood stove. To sit, one must clean animal droppings off furniture. There is no known family. One brother does the talking and one runs away and hides, especially if visitor is a woman. It is hard to know which is which. While sleeping, one of the brothers got bitten on the nose by a rat and got an infection. Their ragged and tattered clothes are held together with baling twine. Existing the way they do causes them to be very frail. No medical care for at least 40 years.

* * * * *

Process

The existance and plight of these brothers is common knowledge to the townspeople, so that the method by which outreach workers were able to meet them was relatively simple to discover.

The brothers on occasion sell manure for garden fertilizer and since both of the outreach workers have large gardens, arrangements were soon made to see the brothers and to purchase fertilizer from them. During this visit, the outreach workers commented on the fact that the Meals-on-Wheels van was at that moment passing by on its way to deliver hot meals to a neighbor. Questions about the meals -- content, availability, cost -- were answered casually, but thoroughly.

The meals van driver happened to be a retired physician well known to the brothers, and so the next day he was asked by outreach workers to stop at the farm and to suggest to the men that they apply for the meals. Other visits to the brothers (and in cooperation with the doctor driver) resulted in one brother agreeing to a physical exam (although he refused any further care), and also applying for Social Security benefits.

The outreach workers were greatly concerned that, given the onset of the bitter winter weather, the brothers, whose health was failing from years of neglect, would freeze to death unless they could be encouraged to accept some warm clothes. The congregate meal site in the town maintained a small thrift shop, so the meal site coordinator stopped at the farm and left the necessary clothing, asking them if they knew of anyone who could or would use it.

Thus, through the efforts initiated by the Project outreach workers these two men were provided with some of the in-service needs. While both appear to have vision problems neither has as yet asked for service.

The following points were made by the outreach workers in the training sessions in which this case was being studied.

"We, as service providers, cannot impose our values on someone else's life style. Sometimes we must settle for only very limited change, and then even moderate change may take years. Outreach workers must understand that these choices belong to the client."

NORTHERN LITES - Background and analysis of development.

The Northern Lites are a locally based group of visually impaired consumers and persons interested in their affairs. They originated as a group in 1977 through the combined efforts of Rose Marie Rogers, a social worker, for the New Hampshire Association for the Blind, and a Humanities Council Grant. At that time, the New Hampshire Association for the Blind was sponsoring cooking classes for the visually impaired and the participants decided to continue meeting on a regular basis. In the interim between 1977 and now, the group has evolved from a primarily socially orientated self-help group, to a wider based entity concerned with advocacy and the interests of all visually impaired citizens.

In 1977, the group had only fifteen members and lacked formal structure. The developmental process has seen the group increase to nearly fifty members, included sighted family and friends. In the winter of 1979, the group adopted a set of formal by-laws with the expressed purpose of "furthering the social, economic and human rights of the blind and visually impaired". At that time the group decided to formally disassociate itself from N.H.A.B. by becoming incorporated with the State as a non-profit organization. This incorporation was seen as a positive step in the group's natural developmental process. It gave the group a formal, independent identity and allowed the members to assume the responsibility that is associated with that independence. The New Hampshire Association for the Blind encourages independence and was pleased to see the group take such a positive step.

The by-laws of the Northern Lites call for each blind member to serve on a committee. This insures total group involvement and enhances the emergence of leadership by giving everyone a voice in the decision making process.

Concrete evidence of the group's interest in community affairs can be seen by the now established practice of inviting guest speakers to their monthly meetings. A sampling of recent speakers include, the Mayor of Berlin, the Director of Legal Aid, a representative from the State Library for the Handicapped, and Berlin's Recreation Director. This suggests an involvement in community affairs and serves the dual function of informing the group and sensitizing key officials to the presence and needs of the visually impaired.

Empirical evidence of the development of advocacy skills can be seen in the recent changes in New Hampshire's property tax exemption for the blind. The Northern Lites was a key agent in increasing that exemption from five to fifteen thousand dollars. This constituted an excellent learning experience into the legislative process and resulted in an increasing sense of self-worth and the ability to work effectively towards change. This effort can also be interpreted as a positive step from self-contained interests towards the interests of the blind population as a whole.

Another key event in the development of the Northern Lites was their recent involvement in the local hospital's evaluation process. The hospital's administrator was concerned with the facilities accessability for the handicapped con-

sumer. He solicited and received recommendations from representatives of the Northern Lites as to what modifications could be made to insure adequate accessability for a handicapped population. This demonstrates that the group's community exposure has resulted in an increasing awareness of the needs of the elderly, visually impaired. It also reinforces the groups sense of community belonging and offers the chance to become involved in planning rather than fall victim to it, as the handicapped population often feels.

The Northern Lites are now firmly established in the community and have many people interested in joining their group to act as sighted volunteers. This has the effect of integrating the visually impaired with the sighted population. The social events that have become so much a part of the group's tradition not only sensitize the general public as to the presence of visually impaired adults, but enable the newly blinded adult to interact in a sympathetic environment and relearn the social skills necessary to his/her adjustment to blindness. The Northern Lites and the Rural Community Service Network Project have mutual goals and our continued cooperation is necessary to meet those goals. The Rural Community Service Network Project social worker attends the group's meetings regularly and acts as liason between the Northern Lites and the New Hampshire Association for the Blind.

A D D E N D A

PERSPECTIVES I & II

I. Since the preparation of this evaluation by the social worker last year, the Northern Lites has experienced a period of uncontrolled growth, increasing their membership to well over 75 people thereby making the sighted membership dominant, at least in gross numbers.

If we accept the premise that the group was formed out of a perceived need to share common experiences and to support one another in the achievement of individual goals, then this influx of sighted members may possibly have one of two opposite effects.

It may serve to challenge the group to retain and preserve its common bond(s) or it may tend to weaken and dilute these bond(s), which were sufficiently strong enough at the outset to give the organizatation its birth and to foster its growth toward independence and autonomy from its sponsor.

One reason for its survival may be that the organization's constitution and by-laws prevent the holding of any office by other than a blind or visually impaired person and limits voting privileges to those with a visual impairment.

II. When any group becomes separate and independent from its parent or sponsoring organization and learns self-advocacy skills, those skills will be tested and quite naturally these first testings will be directed toward the sponsoring agency.

For example, repeated requests were made by Northern Lites members for transportation to one of their recreational events (a bowling league). Since this was not an appropriate use of the grant funds the request was denied and referral was made to the CAP transportation services, which ultimately was also denied since CAP supplies service only for "essential" transportation.

This difficulty remained essentially unresolved at the end of the Project period. It is used merely as an example to point out that conflict between the consumer group and the original sponsoring agency must be examined in view of the larger picture. One of the goals of the Project was to educate the people of Coos

County about blindness and blind people and to integrate the visually impaired person into the active life of the sighted community whenever possible.

While demands for additional kinds of service may at times cause difficulties and pressure within the provider service community, they also have very positive effects, for today the Coos County community is acutely aware that it has a blind and visually impaired population and that this population is comprised of people who have commitments, competencies, needs, ideas and contributions to make.

Success then must be measured not so much in the arena of agreement, but in the arena of involvement.

APPENDIX

APPENDIX

Seminar on Services to Older Blind
Rehabilitation Services Administration
Department of Education
Washington, D.C. - November 1981

Presentation Outline

November 13, 1981

I.	Introduction Aging and Blindness	Henrietta Charest
II.	A Community Profile - Coos County Geographic Social Economic	Henrietta Charest
III.	Historical Background of Rural Community Service Network	Rose Marie Rogers
IV.	R.C.S.N. Project Summary Staffing Methodology - (Social Work (Research (Community Organization	Rose Marie Rogers
V.	R.C.S.N. Project Activities Outreach Advisory Council Seminars Ophthalmological Outreach Pilot	Henrietta Charest
VI.	Findings and Recommendations	Henrietta Charest Rose Marie Rogers

Questions and Answers

NEW HAMPSHIRE ASSOCIATION FOR THE BLIND

Gale N. Stickler
Executive Director

60 School Street
Concord, New Hampshire 03301
Telephone 224-4039

LAMPLIGHTER PRODUCTS

October 30, 1981

Mr. Arthur Cox
Rehabilitation Services Administration
Sweitzer Building
Room 3330
330 C Street
Washington, D.C. 20013

Dear Mr. Cox:

Outline Summaries

I. Introduction

Aging and Blindness
"Age is the single most powerful predictor of blindness and visual impairment."
One-half of all newly blinded adults in the United States are over 65 years of age. The elderly population will increase by nine million (from age 23 to 32) by the year 2000. For those over age 85 this rate of increase will be 84%!

Included are other projections and statistics on aging as well as discussion of four diseases of aging which cause vision loss or impairment. Also examined will be the phenomenon of multiple jeopardy for the aged blind person.

II. Community Profile - Coos County, New Hampshire
Commonly called the north country, the county is a relatively self-contained rural area isolated by geography and distance from more populous areas of southern portions of the state. The area has 38 towns and one city with one industry (the manufacture of paper in two mills) with attendant logging operations. The county is poor with the highest in-state rate of both suicide and alcoholism. The city is culture-bound by a mind set which views stoicism and suffering as positive social values. Service delivery is expensive because of distances and difficult in view of social mores.

III. Historical Background of Rural Community Service Network
The need for a program directed toward elderly blind was a result of public meetings on the topic "A Community Response to Aging and Blindness." Sponsored by the N. H. Council on the Humanities, the data gathered caused New Hampshire Association for the Blind to re-order its priorities and significantly increase the time commitments

of a social worker and a rehabilitation teacher. These staff members conducted two 10-week classes in developing skills for management and independent function, along with on-going social work and rehabilitation teaching to individual clients. An evening meeting group evolved into an active consumer client organization for whom the social worker acted as a group work facilitator. The demonstration project proposal which followed was submitted to R.S.A. based on three years of effort in needs assessment and substantial evidence indicating extensive community support.

IV. R.C.S.N. Project

Staffing consisted of a Project Director, Social Worker, two Outreach Workers and a bi-lingual secretary. The original social worker acted as supervisor to the project Social Worker and as central office liaison. All original staff were native to the community.

Methodology - Project design consisted of three interlocking segments: Social work services, community organization and evaluation and research, the latter provided by independent research facilities of the American Foundation for the Blind. The community organization component used public education presentations and in-service training sessions by outreach staff, while public relations and public information and networking were within the purview of the Project Director. The social worker was responsible for case planning and family counseling, case management, while the research portion was accomplished by way of a Time I - Time II questionnaire administered to 120 respondents.

V. Project Activities

Outreach - While public education and in-service training presentations were ordinarily used to educate community, more unique methods were effected through church congregations and banks.

Advisory Council - Voluntarily included in the proposal, it was designed along conventional lines and required that at least one-third of its members be vision impaired. This council was significantly restructured at the end of Year II of the Project.

Seminars: Blindness & Diabetes, Advocacy & Consumerism.
The former was conducted for professionals in health and health-related fields and included lectures by area physicians on the following: The Patho-physiology of Blindness & Diabetes and Lasers as a Treatment Modality for Diabetic Retinopathy. Other topics treated were socio-psychological aspects of blindness and diabetes as well as examination of developments in technology for the visually handicapped diabetic.

Advocacy - Presented to Advisory Council members, this seminar dealt with the development of skills and methodologies of successful advocacy and consumers as team members. Also treated was discussion of those skills necessary to establish effective collaboration between consumers and providers. The principal speaker at this seminar was Mr. William Gallagher, now Executive Director of American Foundation for the Blind.

VI. Ophthalmological Outreach Pilot Study

Operating on the premise that the nursing home patient is physically able to travel the required 60 - 100 miles to visit the one area ophthalmologist, a pilot study was conducted to test the feasibility of providing eye care in two area nursing homes. The agency mobile low vision van was used and services of optometrists and ophthalmologist made available to any patient interested in an eye examination. The data collected indicated a significant amount of eye disease and visual dysfunction. Two conclusions accrued from this study - the need for better eye care for the institutionalized elderly person and the needs which may exist in institutions located in other parts of the state.

Findings and recommendations will be furnished by the presenters, Henrietta Charest, Project Director, and Rose Marie Rogers, Central Office Liaison.

Sincerely,

Henrietta Charest
Project Director

HC:jj

NEW HAMPSHIRE ASSOCIATION FOR THE BLIND

Gale N. Stickler
Executive Director

60 SCHOOL STREET
CONCORD, NEW HAMPSHIRE 03301
Telephone 224-4039

Lamplighter Products

Berlin Office
101 Norway St.
Berlin, N. H. 03570
Tel. 752-7043

April 25, 1979

Services
Social Casework
Rehabilitation Teaching
Peripatology
Volunteer and Recreation
Homebound Craft Program
Public Education
Prevention
Professional and Public Information

Dear

The New Hampshire Association for the Blind is considering offering classes for blind and visually impaired persons in your area.

These classes will be held at the Colonel Town House in Lancaster, beginning at the end of May. Classes will run for six weeks and probably be held on a week-day from 9:00 a.m. to 2:00 p.m. These classes will be FREE and cover all aspects of daily living. Enclosed is a list of possible areas to be covered.

If you feel you might benefit from these classes, please go through the enclosed list and indicate your areas of interest. Also, if transportation is a problem, please check the line on the bottom of the second page.

I would appreciate that you take the time to let me know if you would be interested in these classes by returning the list to me in the self addressed stamped envelope.

If you have any questions or comments, please feel free to call me at 752-7043. I will be looking forward to hearing from you and receiving your reply.

Sincerely,

Russell K. Landry

Russell K. Landry
Social Worker, N.H.A.B.

RKL/mm
enclosures

THE NEW HAMPSHIRE ASSOCIATION FOR THE BLIND

announces

FREE CLASSES FOR BLIND PEOPLE IN BERLIN, NEW HAMPSHIRE

FOR TEN WEEKS ON WEDNESDAYS AND THURSDAYS

BEGINNING APRIL 26 & 27, 1978 THROUGH JUNE 21 & 22, 1978

W E D N E S D A Y S :

Arts and Crafts - 1:00 - 2:30 p.m.
First Avenue, Berlin, N.H.

Abacus - 3:00 - 4:00 p.m.
(A tactual arithmetic system)
Housing Authority
Granite Street, Berlin, N.H.

Typing - 4:00 - 5:00 p.m.
Housing Authority
Granite Street, Berlin, N.H.

T H U R S D A Y S:

Cooking, Homemaking and Nutrition - 9:00 - 11:00 a.m.
Salvation Army Kitchen, Cole Street, Berlin, N.H.

REGISTRATION FORM (Please return to the New Hampshire Association for the Blind, 60 School Street, Concord, New Hampshire 03301, Tel. 224-4039)

Name:_____ Tel. No._____

Address:_____

Please check class desired:

Arts & Crafts, 1:00 - 2:30, Wednesdays....._____
List Craft desired_____
Abacus, 3:00 - 4:00 p.m., Wednesday....._____
Typing, 4:00 - 5:00 p.m., Wednesday....._____
Cooking, Homemaking & Nutrition, Thursday....._____

We request that you sign up for only two classes.

V I

A "typical" Public Education Program at a Senior Meal Site.

We arrive before lunch so that we can do some informal visiting with the Seniors. This allows us to hear if there are any problems or needs to which we can address ourselves or that we can refer to the Social Worker. These things come out more readily in this type of informal setting rather than at a formal visit.

As the dessert arrives, we start our program, in this way the audience is not apt to leave. (A captive audience so to speak.)

Normally our program begins with an introduction to, and a definition, of, the many kinds of blindness/visual impairment. This clears up some of the many misconseptions about the term "blindness". Previous to this program many people think that blindness means total blackness. When it is explained to them that a person may be considered "legally blind" but will still see things (with variations) may work, play and live a very "normal" life; they begin to see blindness/visual impairment in a very different way.

Next, we follow with a series of demonstrations 1) "Sighted Guide" techniques, 2) pouring of water, 3) walking with a cane and 4) eating. Each of these is done by asking for volunteers from the audience and having them participate with us. It provides some humor and gives the audience the feeling of being without sight temporarily.

We often use the film entitled "What Do You Do When You Meet A Blind Person". This film has a great deal of humor and approaches the problem of blindness in a very informal way but much can be learned from it.

Next, we display visual aids, and explain their use. We demonstrate how they can be made from things right in a persons' own home. We explain that all of the services are free. We show some of the items made in the Home Crafts Department of the Agency and explain that even though a person is blind it does not mean that they have to stop living a useful, creative and independent life.

The program closes with a discussion of what the services are, how to get them, who to contact, and the method by which you can get services for a "friend".

It is very important before beginning a program to alert yourself to that days' situation, the mood of the audience, whether or not they are ready to hear hard facts about blindness or if you will have to talk vaguely about this subject for now; how long they are going to sit and whether or not you are holding their interest. We also feel that being on a first name basis with many of the Seniors (they all treat you like a grandchild) is helpful in promoting interest. We stress independence rather than dependence. We explain that one of our professional staff members will be available to personally call on them.

IN - SERVICE TRAININGS:

Coos County Institution (Nursing Home - County Farm - Jail)
Coos County Nursing Home
St. Vincent de Paul Nursing Home
Morrison Nursing Home
Country Village Health Care Center (formerly Kent Nursing Home)
Upper Connecticut Valley Hospital (Nursing and Medical Staffs)
Weeks Memorial Hospital (Nursing, Medical and Administration Staffs)
Public Health Nurses (all three organizations)
Visiting Nurses (Berlin, Lancaster and Colebrook)
Expanded Food and Nutrition (UNH/CES Home Visitors) (Berlin)
Chore Service (Berlin)
Home Health Aides (Berlin)
Teachers (All of the towns in Coos County)
Firemen (Berlin, Stark, Errol, Milan, Lancaster, Whitefield, Colebrook)*
Policemen (Berlin, Lancaster, Groveton, Colebrook, Whitefield) *
Ambulance Drivers and Attendants
Sheltered Workshop Staffs

* These were the locations of the In-Service but often surrounding towns attended these meetings. All but one were volunteers serving the depts.

PUBLIC EDUCATION PROGRAMS:

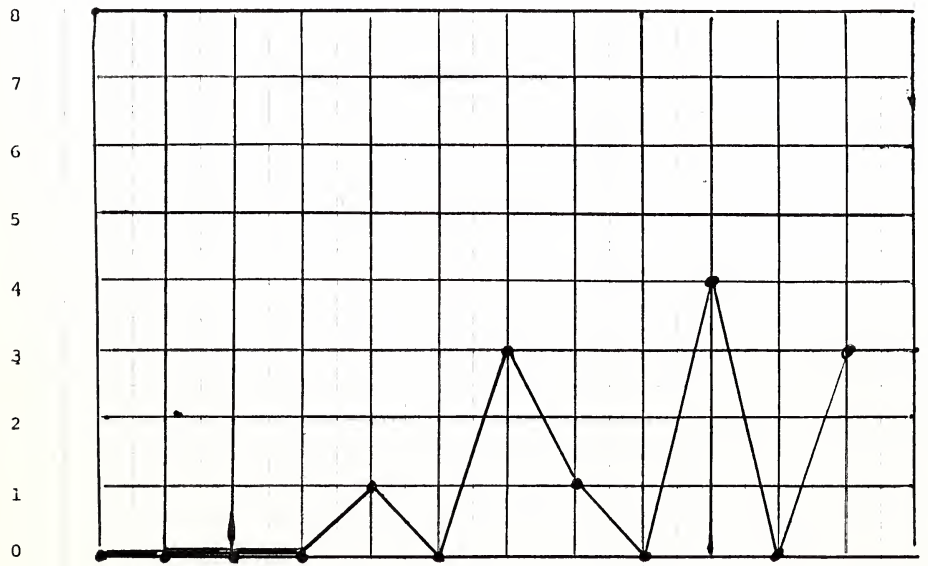
Schools (in every town but one in the county ~~many times 5 or 6 in one day~~).
Church Groups
Granges
Women's Clubs
Rotary
Lions
Kiwanis
Masons
Eastern Star
Retired Teachers
Snowmobile Clubs
Ski-clubs
4-H (Also did training of the youth to work on an inter-generational project)
RSVP (Members of this staff were on the Advisory Council)
Sisters of Mercy and Presentation of Mary
Senior Citizen Clubs
Senior meal sites
Head Start Programs
Association of County Clergy
P.T.A.
Faculty of grade schools, high schools and vocational and technical colleges
Professional organizations
Bank staff
Town government employees
Union membership

ALPHABETICAL LISTING

Human Service Agencies in Coos County

NEW REFERRALS

(prior to RCSN Project)



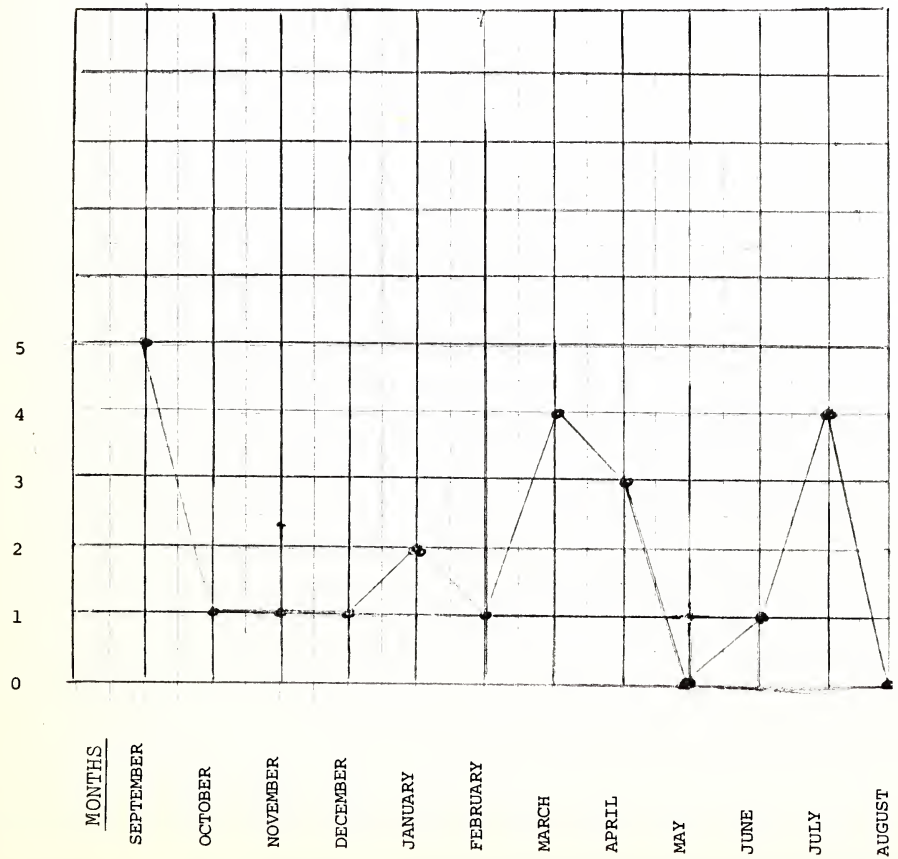
SUMMARY

September	0
October	0
November	0
December	0
January	1
February	0
March	3
April	1
May	0
June	4
July	0
August	3
Total	12

1977 - 1978

NEW REFERRALS

(prior to RCSN Project)



SUMMARY

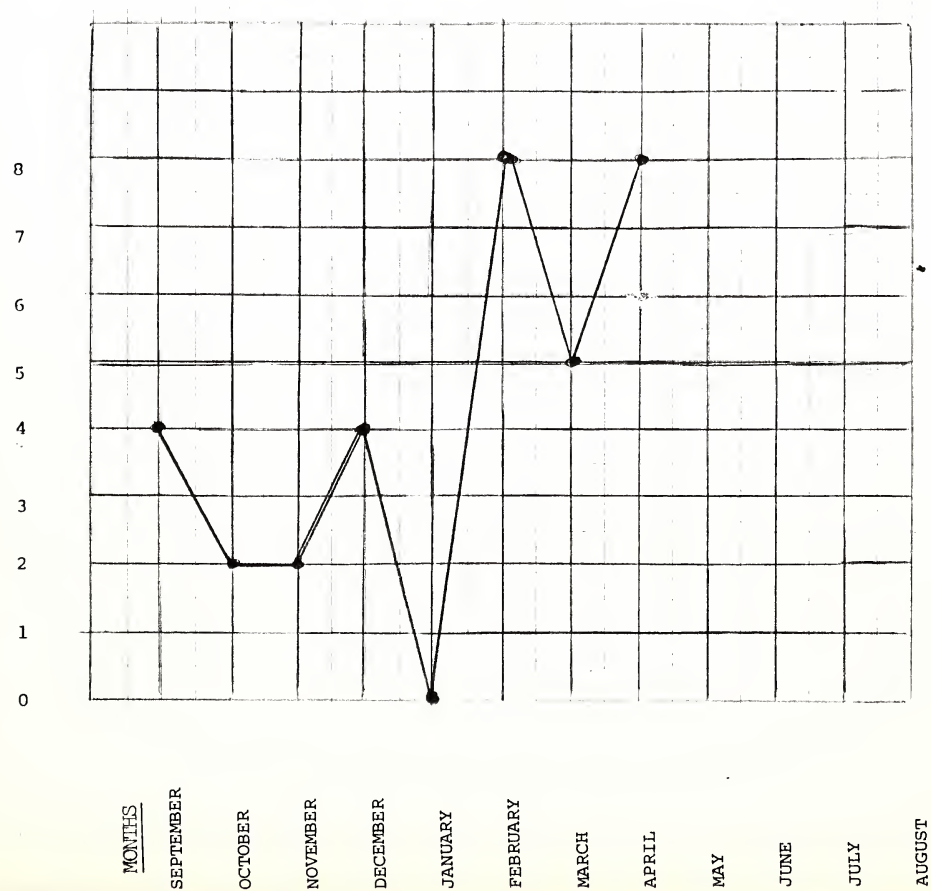
September	5
October	1
November	1
December	1
January	2
February	1
March	4
April	3
May	0
June	1
July	4
August	0

1977-1978 Total 23

SEPTEMBER 1978 - AUGUST 1979

NEW REFERRALS - RCSN PROJECT

YEAR I



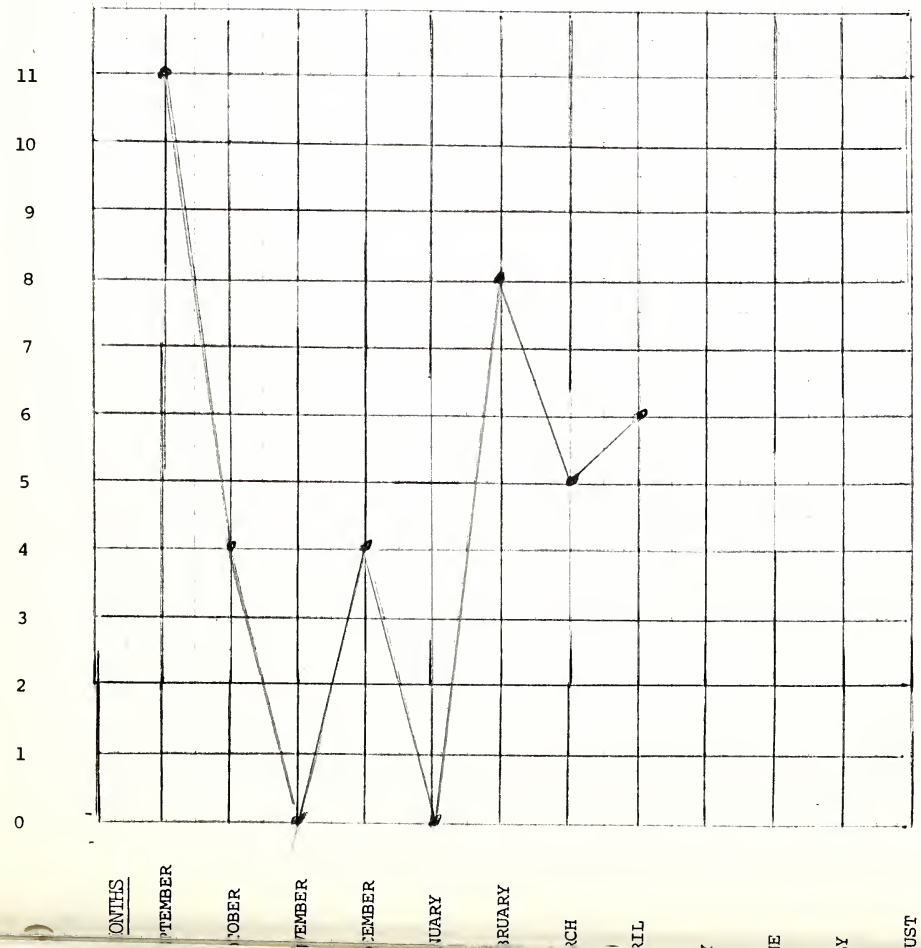
SUMMARY

September	4
October	2
November	2
December	4
January	0
February	8
March	4
April	8
May	
June	
July	
August	
Total	32

SEPTEMBER 1979 - AUGUST 1980

NEW REFERRALS - RCSN PROJECT

YEAR II

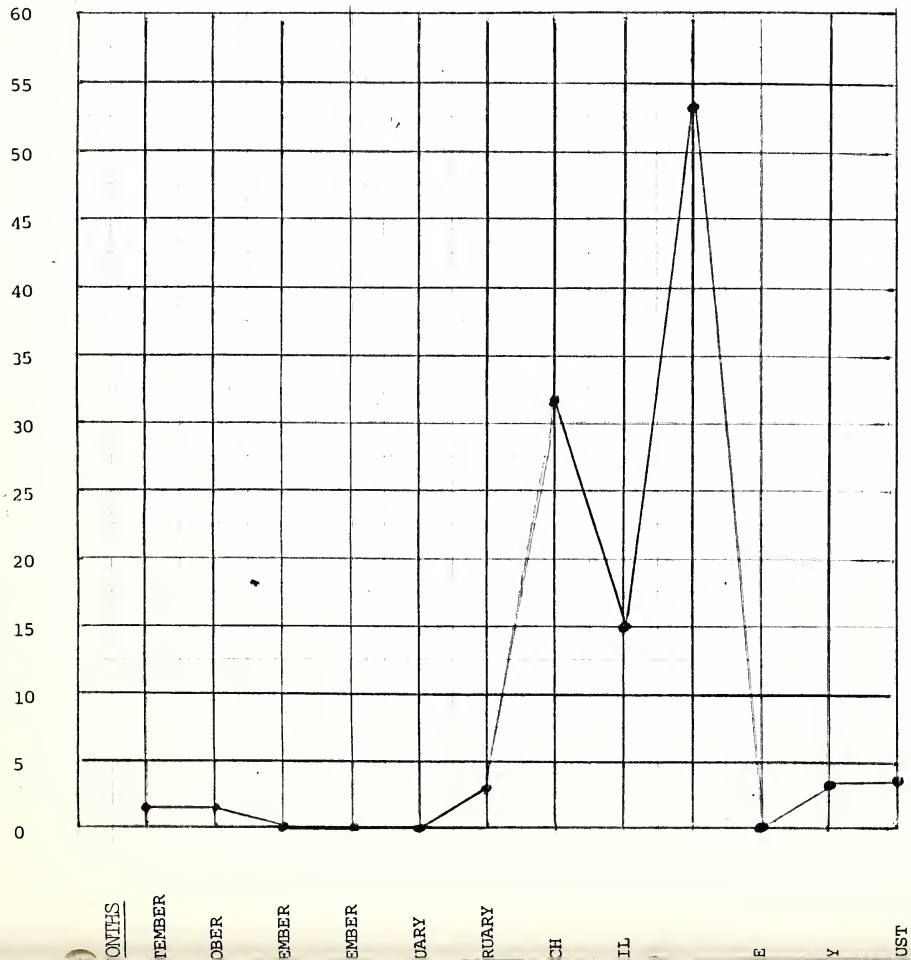


SUMMARY	
September	11
October	4
November	0
December	4
January	0
February	8
March	5
April	6
May	
June	
July	
August	
Total	38

SEPTEMBER 1980 - AUGUST 1981

NEW REFERRALS - RCSN PROJECT

YEAR III



SUMMARY

September	2
October	2
November	0
December	0
January	0
February	3
March	32
April	15
May	53
June	0
July	3
August	3
Total	113

NEW HAMPSHIRE ASSOCIATION FOR THE BLIND

N. Stickler
Executive Director

60 SCHOOL STREET
CONCORD, NEW HAMPSHIRE 03301
Telephone 224-4059

Lamplighter Products

Berlin Office
101 Norway St.
Berlin, N. H. 03570
Tel. 752-7043

The New Hampshire Association for the Blind has developed a special project for Blind and Visually Impaired persons in Coos County.

One objective of the project is to inform the general public, but especially the elderly, of services available to them. In order to accomplish this task, we have developed a public education and information program which we would like to present to your group.

The program consists of an introductory talk, film, display and explanation of visual aids, handicrafts, explanation of services available and an open discussion. This program lasts about forty-five minutes. The films are titled: "What Do You Do When You Meet a Blind Person", a humorous but realistic approach to real life situations in the world of blind persons; "Not Without Sight", a more in depth film describing the various types and causes of blindness.

We are now preparing our summer, fall and winter schedule, and if your group is interested, we would appreciate your contacting this office as soon as possible. Additional information may be obtained by contacting our office at 101 Norway Street, Berlin, NH 03570, telephone 752-7043.

We have enclosed a "Request for Program" form, and a self addressed, stamped envelope for your convenience.

Sincerely,

Henrietta Charest
Project Director

HC/mm
enc.

REQUEST FOR PROGRAM - NEW HAMPSHIRE ASSOCIATION FOR THE BLIND

Date:
Initial:

1. Name of School

2. Date of Meeting:

3. Time:
(May program be shown before business meeting?)

4. Place:

5. Estimated Attendance:

6. Name of Person Making Booking:
Address:
Phone:

7. Program Desired:
a. Movie:
16 mm sound projector available

b. Slides:
Screen available

c. Display of Blind-made Items:

d. Display of Material Aids:

e.

f.

REMARKS:

NEW HAMPSHIRE ASSOCIATION FOR THE BLIND

PROGRAM REPORT R.C.S.N. P.E. + OUTREACH

DATE:

Initial:

Name of Organization: _____

_____

Date of Program: _____ Time: _____

Address of Program: _____

_____

Attendance: _____

_____

Program consisted of: _____

_____

_____

Film Title: _____

Slides Title: _____

Items Displayed: _____

_____

Literature Distributed: _____

_____

Names of Staff & non-staff persons attending: _____

_____

Contact Person: _____
(address) (tel.)

Remarks:

NEW HAMPSHIRE ASSOCIATION FOR THE BLIND

RURAL COMMUNITY SERVICE NETWORK PROJECT

ADVISORY COUNCIL

BY-LAWS

ARTICLE 1

The name of this Council shall be The Advisory Council of the Rural Community Service Network Project of Coos County for the New Hampshire Association for the Blind.

ARTICLE 11

The object of the Advisory Council shall be to advise and recommend to the Project Director and Staff a course of action, to comment, review, and to propose alternative courses of action, and to issue minority and majority reports.

ARTICLE 111 (A)

Members:

The voting membership size and profile shall be maintained as follows:

1. To consist of 15 members.
2. 1/3 of whom must be consumers or potential consumers of services who are over the age of 55.
3. 1/3 of whom must be providers of services. (5)
4. 1/3 of whom must be representatives of the community at large, (5) ie.
    a) Businesses.

b) Public interest groups.

c) Community organizations.

d) Labor.

e) Clergy.

ARTICLE 111 (B)

Council members may submit nominations of new members to the Nominating Committee for presentation to the Council at large for approval.

ARTICLE 111 (C)

Members will be appointed by the Chairperson for a 3 year term of office.

ARTICLE 111 (D)

If a vacancy occurs on the Council, The Chairperson shall appoint a replacement to fulfill the unexpired term (appointed shall be a person who represents the same category of membership).

ARTICLE 111 (E)

Absence for 3 consecutive meetings without contact shall be considered as reason for termination of membership with notification given by registered mail.

ARTICLE 111 (F)

Any person/persons, may be appointed by the chairperson and may participate in discussion but may not vote.

Article lV

Officers:

The Officers shall be elected by a majority of the membership for a 1 year term at the annual meeting which is to be held in August.

The Chairperson is the only official authorized spokesperson for the Council in regard to policies and positions for public release. However, each person has the right to express his/her personal opinions.

A) Officers shall consist of Chairperson and Vice Chairperson.

B) The Chairperson shall:

1. Preside over all regular and special meetings.
2. Appoint members to working committees.
3. Set the agenda for regular and special meetings in consultation with the Project Director and Council Members as may be necessary.
4. Receive a written report from the Project Director once a month.

The Vice Chairperson shall:

1. Assume all duties of presiding officer in the absence of the Chairperson.

ARTICLE V

Meetings:

(A)

The Advisory Council will meet monthly at adequate facilities provided by the Rural Community Service Network Project.

(B)

Special (or emergency) meetings may be called at the discretion of the Chairperson, providing that all members of the Council are notified in writing or telephone as to the purpose of the said meeting, its time and place.

(C)

Secretarial services to the Council will be provided by the Rural Community Service Network Project Staff.

(D)

Transportation will be provided to and from meetings to Consumer Members of Council whenever needed.

(E)

NHAB/RCSN will provide transportation to Council Meetings when other arrangements cannot be made.

ARTICLE Vl

Voting:

(A)

In order to consider a meeting valid, a quorum must be present. A quorum shall consist of 5 Council Members who are present and voting.

(B)

In the absence of a quorum, the Chairperson may, at his or her discretion, conduct a meeting of those present and proceed with business with the understanding that any resulting decisions will be subject to vote on at the next meeting.

ARTICLE Vll

Amendments:

These By-Laws can be amended at any regular Council meeting by a majority vote of the members present and voting provided that this amendment has been submitted in writing.

ARTICLE Vlll

Committees:

Standing and ad hoc committees will be set up by the Chairperson as a needed basis.

DESCRIPTIONS OF THE GENERAL FUNCTIONS OF AN ADVISORY COUNCIL

In general every advisory group has several options available to it. It may propose a course of action, and it may comment on a proposed course of action which has been submitted to it.

An advisory group can and should express it's priorities, as well as recommend alternative courses of action. An advisory council may certainly influence policy decisions, but it does not make those policies, nor does it determine the final decisions of the agency.

Policies are implemented by the governing body of the organization. Commonly this is a board of directors who are ultimately responsible for both the fiscal and programatic activities of the organization.

The procedural guidelines of an advisory council can best be outlined through a set of articles set forth in by-laws adopted by the advisory council members.

The weight of the advice of an advisory group is often a direct reflection of the thoroughness of it's work.

In summary, an advisory council is charged with recommending, prioritizing, reviewing and commenting on the various activities of the organization which it seeks to serve.

PROPOSED RESTRUCTURING OF ADVISORY COUNCIL

In general, an Advisory Council is charged with recommending, prioritizing, reviewing and commenting on the activities of the program which it seeks to serve. These activities on the part of the Advisory Council enables the program to "keep its finger on the pulse of the community", so to speak.

Within these very general categories of activities are included a number of very specific areas which combine to strengthen and support community ties.

1. Principally, the Council serves as a source of informational feed back from the community by which the program, and its sponsoring agency, can assess both its services in response to emerging needs, and the manner in which they can best be delivered.
2. It serves to interpret the program's goals and services to the community at large.
3. It counsels and assists in the planning of the program's outreach efforts.

Traditionally, the structure of an advisory group consists of approximately 10 to 15 community representatives who meet periodically in a specified place. However, whatever structure is chosen it must be designed so that it is representative of the entire community. First, its membership composition should provide for the participation of consumers, other human service providers and the lay public.

In addition, its membership should be as broadly representative of the geographical area served as possible.

In rural areas such as ours, the latter is commonly the most difficult to achieve. The experiences of other agencies and experts in the field of voluntary committees and boards, indicate that moving these meetings from location to location does not work in terms of enhancing membership participation to any significant degree. What it does in fact, is tend to simply develop over time into two or three fragmented groups.

Fair and equitable geographic representation is both desirable and necessary. Since the present Rural Community Service Network Advisory Council structure does not readily promote that representation, it has become necessary to give careful consideration to altering the present structure to one in which this goal of balanced geographic representation can best be achieved.

An alternative structure for the RCSN Advisory Council which would solve this problem of inadequate geographic representation is herein proposed for comment and review.

A) That five committees be formed.

B) That these committees be selectively located in, Berlin(2)-Whitefield - Lancaster - Colebrook

C) That these committees consist of three members, and that they be one consumer, one human service provider, and one representative of the business/lay public.

D) That of the two committees in Berlin, one consist wholly of members of the Northern Lites, due to the larger number of consumers in this geographic area.

E) That these committees meet periodically with a designated staff person(s) and that appropriate written records be kept.

F) That the staff person(s) serve as the coordinator and general liason person between committees.

G) That these committees be structured so that each member has a special area of responsibility, and that these people meet across committees to discuss their common areas of interest and responsibility as often as is deemed necessary.

It is proposed that these special areas of interest be devided into the following three categories.

CATEGORY 1 To assist staff to facilitate opportunities for public education presentations in the community.

CATEGORY 2 To assist staff to facilitate opportunities for the collaboration and cooperation between our program and other service providers serving elderly persons within the community.

CATEGORY 3 To identify the natural helpers within the community and through collaboration with them to identify the emerging and/or unmet needs of the elderly visually impaired persons in the community.

RATIONALE:

The Rural Community Service Network Project is a demonstration project and is by definition committed to examine and test new and innovative ways in which to serve rural areas.

At the same time other considerations must be made. The Project has only one year more of federal dollars in which to test a new concept; there are at present (4) four board vacancies. In addition, the prohibitive costs of gasoline make it wise to consider the value of transportation costs which are limited by moving the staff designee rather than an entire council.

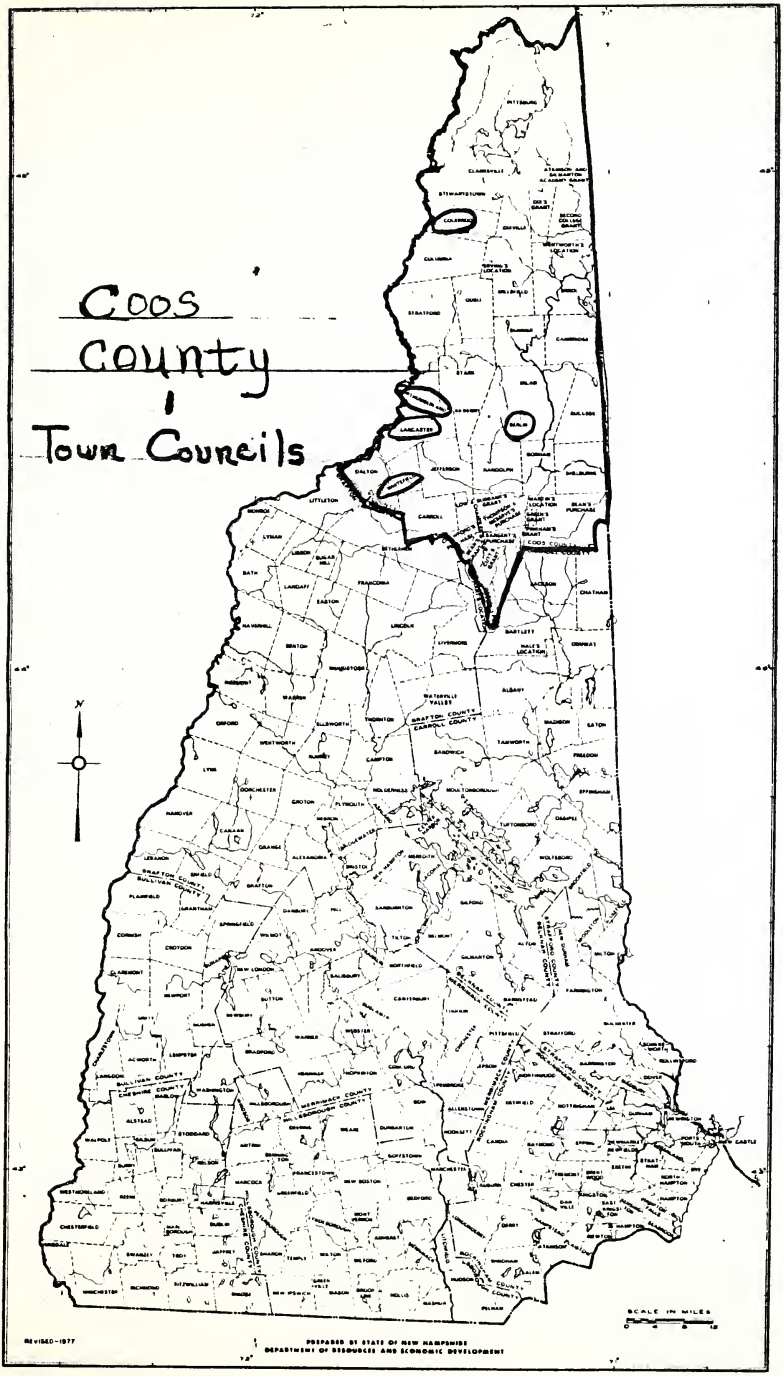
In summary, if we accept the premise that the major role of an adivsory council is to "keep its finger on the pulse of the community", as well as to serve as a source of informational feed back from the community then it would seem prudent to adopt a structure which can most successfully accomplish these objectives.

This restructuring proposal is therefore submitted to the Rural Community Service Network Advisory Council for its comment and review at its next regularly scheduled meeting.

Respectfully submitted:_____

Henrietta Charest, Project Director
Rural Community Service Network
Project

Date: August 14, 1980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PREPARED BY STATE OF NEW HAMPSHIRE
DEPARTMENT OF RESOURCES AND ECONOMIC DEVELOPMENT

NEW HAMPSHIRE ASSOCIATION FOR THE BLIND
101 Norway Street Berlin, New Hampshire

TO: Health Community

RE: Seminar on Diabetes and Blindness

FROM: New Hampshire Association for the Blind
Berlin Office

You are cordially invited to attend a day-long seminar on diabetes and blindness sponsored by New Hampshire Association for the Blind, Berlin Office, on Monday, May 19, 1980, from 9:00 A.M. to 4:00 P.M., at the Androscoggin Valley Hospital Lecture Room.

As a part of its Rural Community Service Network project here in the North Country, the Association for the Blind is committed to taking a leadership role in area efforts to improve service delivery to the elderly and visually impaired population, and to the early identification of diabetics who may be in crisis.

As a part of that commitment, the Rural Community Service Network project seeks to develop those methods which will best enable the health community to identify and serve diabetics. In addition, it seeks to design a delivery system which will link them and their families to the latest information and treatment modes which are currently available.

Presenters at the seminar include an area physician who will discuss the medical aspects and systemic effects of diabetes. Dr. William Foord will show a slide presentation on laser treatments for diabetic retinopathy. A national consultant on rehabilitation will speak on the psycho-social aspects of diabetes and blindness. In addition, a reactor panel will analyze these topics from the points of view of a nurse, a dietitian, a social worker, and a licensed practical nurse who is a diabetic instructor and who is, herself, a diabetic.

A complete agenda will be sent to you within a few days.

Please share this information with other colleagues who may wish to attend.

If you have any questions please contact the Berlin office of New Hampshire Association for the Blind at 752-7043.

Henrietta Charest
Project Director

HC:jj
5/80

SEMINAR ON BLINDNESS & DIABETES

Sponsored by

The New Hampshire Association for the Blind -
Rural Community Service Network Project

at

Androscoggin Valley Hospital
Lecture Room
Page Hill Road
Berlin, New Hampshire 03570

MAY 19, 1980

MORNING SESSION:

9:00 - 9:20	INTRODUCTION TO SEMINAR Mr. Morton M. Kleinman Regional Consultant American Foundation for the Blind
9:30 - 10:30	MEDICAL ASPECTS & SYSTEMIC EFFECTS of DIABETES Normand Couture, M.D.
10:30 - 10:45	BREAK
10:45 - 11:00	INTRODUCTION Gale N. Stickler, Executive Director New Hampshire Association for the Blind
11:00 - 12:00	LASER TREATMENTS FOR DIABETIC RETINOPATHY William D. Foord, M.D., Opthalmalogist
12:00 - 1:00	LUNCH
1:00 - 1:15	INTRODUCTION Mr. Morton M. Kleinman Regional Consultant American Foundation for the Blind
1:15 - 2:15	PSYCHOLOGICAL/SOCIAL IMPLICATIONS OF DIABETES AND BLINDNESS Mr. Albert Asenjo National Consultant for Rehabilitation American Foundation for the Blind
2:15 - 2:30	BREAK

2:30 - 2:45	INTRODUCTION Ms. Henrietta Charest R.C.S.N. Project Director
2:45 -	PANEL MEMBERS ..... MODERATOR - Rose Marie Rogers, A.C.S.W. Social Worker for N.H.A.B Florence Cote, R.N. / Linda Lusier, R.N. Doris Surette, N.P. / Linda Letellier L.P.N

The panel will discuss the day's presentations from the special viewpoints of their varying desciplines.

Rose Marie Rogers, A.C.S.W.	The concerns for the visually impaired diabetic and his/her family from the social work viewpoint.
Florence Cote, R.N. Linda Lusier, R.N.	A Nurse's viewpoint
Doris Surette, N.P.	a) Diet b) The entrance of the diabetic into the health care system. c) Gerontology & Diabetes
Linda Letellier, L.P.N.	A personal viewpoint

** Coffee will be provided

*** Lunch may be purchased at the A.V.H. cafeteria

For additional information call - N.H.A.B. office - 752-7043

NEW HAMPSHIRE ASSOCIATION FOR THE BLIND
101 Norway Street Berlin, New Hampshire

TO: Health Community

RE: Seminar on Blindness and Diabetes

FROM: New Hampshire Association for the Blind
Berlin Office

You are cordially invited to attend a day-long seminar on blindness and diabetes sponsored by the New Hampshire Association for the Blind, Berlin Office, on Wednesday, October 22, 1980, from 9:00 a.m. to 4:00 p.m. at the United Methodist Church Hall in Lancaster, NH.

As a part of its Rural Community Service Network project here in the North Country, the Association for the Blind is committed to taking a leadership role in area efforts to improve service delivery to the elderly and visually impaired population, and to the early identification of diabetics who may be in crisis.

As a part of that commitment, the Rural Community Service Network project seeks to develop those methods which will best enable the health community to identify and serve diabetics. In addition, it seeks to design a delivery system which will link them and their families to the latest information and treatment modes which are currently available.

Presenters at the seminar include Dr. Pancras vanderLaan, who will discuss the medical aspects and systemic effects of diabetes. An area ophthalmologist will speak on the treatment modalities for eye diseases including the use of lasers in the treatment of diabetic retinopathy.

Ms. Paula Mazzio, a vocational rehabilitation counselor from the staff of the Carroll Center for the Blind in Newton Massachusetts, will address the issue of the psychosocial aspects of diabetes and blindness.

A reactor panel consisting of a social worker and several nurses representing varying aspects of the profession will complete the seminar.

A complete agenda will be sent to you in the next few days.

A registration fee of $3.00 is required. This includes the cost of coffee and lunch.

Please share this invitation with any other colleague you think may wish to attend.

If you have any questions please contact the Berlin office of the New Hampshire Association for the Blind at 752-7043.

Henrietta Charest
Project Director

HC:mm
10/80

SEMINAR ON BLINDNESS & DIABETES

Sponsored by

The New Hampshire Association for the Blind -
Rural Community Service Network Project

at

United Methodist Church Hall
135 Main Street
Lancaster, New Hampshire

October 22, 1980

A.M. SESSION:

9:00 - 9:20	INTRODUCTION TO SEMINAR Mr. Morton M. Kleinman Regional Consultant American Foundation for the Blind
9:30 - 10:30	MEDICAL ASPECTS & SYSTEMIC EFFECTS of DIABETES Pancras vanderLaan, M.D.
10:30 - 10:45	BREAK
10:45 - 11:00	INTRODUCTION Gale N. Stickler, Executive Director New Hampshire Association for the Blind
11:00 - 12:00	TREATMENT MODALITIES OF EYE DISEASES Ophthalmalogist, Gault M. Farrell, M.D. Faculty, Dartmouth-Hitchcock Medical School

P.M. SESSION:

12:00 - 12:45	LUNCH
12:45 - 1:15	INTRODUCTION / DEMONSTRATION of DEVICES for VISUALLY IMPAIRED DIABETICS Mr. Morton M. Kleinman Regional Consultant American Foundation for the Blind
1:15 - 2:15	PSYCHOLOGICAL/SOCIAL IMPLICATIONS of DIABETES and BLINDNESS Ms. Paula Mazzio Carroll Center for the Blind Newton, Massachusetts
2:15 - 2:30	BREAK

2:30 - 2:45 INTRODUCTION
Ms. Henrietta Charest
R.C.S.N. Project Director

2:45 - PANEL MEMBERS .....

MODERATOR - Terrie Judge, R.N.,B.S.N.
In-Service Coordinator
B.D. Weeks Memorial Hospital
Lancaster, New Hampshire

Rose Marie Rogers, A.C.S.W.

Ms. Paula Mazzio, Voc. Rehab. Counselor

Marion McCaig, R.N.

The panel will discuss the day's presentations from the special viewpoints of their varying desciplines and will focus their comments on the following areas.

A) Statement of problems encountered in dealing with the visually impaired diabetic.

B) How nurses and other health professionals recognize the signs and symptoms of the visually impaired diabetic.

** Coffee & lunch will be provided

*** For additional information call - N.H.A.B. office - 752-7043

HC:mm
10/80

NEW HAMPSHIRE ASSOCIATION FOR THE BLIND

Gale N. Stickler
Executive Director

60 SCHOOL STREET
CONCORD, NEW HAMPSHIRE 03301
Telephone 224-4039

Lamplighter Products

Berlin Office
101 Norway St.
Berlin, N. H. 03570
Tel. 752-7043

ADVOCACY SEMINAR
Announcement

DATE: April 29, 1980
PLACE: Berlin Housing Authority
TIME: 10:00 a.m. to 4:00 p.m.

PURPOSE:

The Seminar is designed to acquaint participants with various aspects of advocacy and consumerism which will enable them to develop the skills and methodologies necessary to favorably impact and influence services for blind persons in the community and the State.

PRESENTERS:

A. Principal Speaker - Mr. William Gallagher
Associate Director of Advocacy for A.F.B.

B. Moderator - Mr. Morton M. Kleinman
Regional Consultant for A.F.B.

C. NH Legislative Expert - Honorable Laurier Lamontagne
New Hampshire State Senator

Mr. Gallagher is a graduate of the Perkins School, did his undergraduate studies at Holy Cross and his graduate studies at Boston College.

He began his work in the blindness field in 1954, has worked at the Lite House in New York and with the Catholic Guild (now the Carroll Center) in setting up the St. Paul's Rehabilitation Center as well as serving as a faculty member at the University of Pittsburg in - Special Education and Rehabilitation.

Recently appointed by Governor Carey of New York, Mr. Gallagher is one of the five commissioners for the Blind serving New York State.

SPECIAL NOTE
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Transportation and lunch will be provided.
Please call the office at - 752-7043 - to make transportation arrangements and to order lunch on or before FRIDAY, APRIL 25th.

Thank you.

ADVOCACY SEMINAR
April 29, 1980

MORNING SESSION 10:00 a.m. / 12:30 p.m.
****

Introduction: Mr. Morton M. Kleinman - American Foundation for the Blind

Presentation: Mr. William Gallagher - Associate Director of Advocacy for A.F.B.

CONSUMERISM: a) Advisory Council Membership

b) Effective relationships and collaboration between consumers and providers.

c) The consumer as a team member.

LUNCH: 12:30 to 1:30
*****

AFTERNOON SESSION 1:30 p.m. / 4:00 p.m.
****

Introduction: Mr. Morton M. Kleinman

Presentation: Mr. William Gallagher

ADVOCACY: TITLE: "HOW TO FIGHT FOR A CAUSE WITHOUT CAUSING A FIGHT"

a) Skills and methodology of successful advocacy.

b) ISSUES:

1. Identification
2. Prioritizing
3. Strategies
4. Solutions

c) A legislative kit would be developed. Senator Laurier Lamontagne will act as N.I.B. legislative expert.

OPHTHALMALOGICAL OUTREACH PILOT STUDY

The Project social worker and outreach workers have observed a quantity of elderly, visually impaired persons who are unable to receive services or legal benefits. These people reside in nursing homes or live in remote areas. Most belong to the older, elderly group from 75 years of age of older. In addition to age they may also have multiple disabilities. Usually they have limited financial resources.

The reason they are underserved or unserved is that most services and benefits require an ophthalmalogical examination and report. Independent living services, vocational rehabilitation, low vision programs, property tax and income tax exemptions, to name a few, all require a prior ophthalmalogical examination and report. These examinations reports are used to determine eligibility for most services and benefits.

In this rural area these older, elderly people are unable to physically tolerate the combination of substantial travel (as much as 60 miles each way) and an ophthalmalogical examination (usually 2 hours). Many have not seen an eye doctor in many years.

They need a program to determine their present eye condition (diagnosis and prognosis), its' treatability and its' indication of approval for legal benefits and services. An ophthalmalogical outreach would provide a needed service to many elderly who would not otherwise receive eye glasses,

ophthalmalogical examination medical treatment for eye diseases. Since their visual status would be known, both benefits and services would become available to them.

We propose to conduct a pilot study of ophthalmalogical outreach which would incorporate the expertise of ophthalmologist/optometrist team in the agency's mobile clinic in the following plan.

Activity 1. Conduct a survey of ophthalmologists/optometrists in the area to learn if they make home visits as feasible.

Activity 2. Utilize and train project outreach workers to conduct vision screenings in nursing homes and possible in home visits as well as make referrals to social workers for intake purposes.

Activity 3. Use social work services and complete case findings to determine ophthalmalogical needs, eligibility for services, and referral to outreach team.

Activity 4. In selected nursing home(s), obtain cooperation of administration to conduct a series of eye clinics. An ophthalmalogist and an optometrist would be engaged to determine diagnosis, prognosis, refractive errors prescribe eye glasses and prepare eye reports. The low vision van and its equipment would be present so that a complete ophthalmological and optometrist evaluation(s) could be made.

Activity 5. The project social worker would cooperate with the home's social worker to develop and implement a

treatment plan which could include other services such as low vision when deemed appropriate. Selected clients who may be residing in the immediate area of the home and are homebound but are able to travel short distances may be included in the pilot study as appropriate.

SELECTED REFERENCES

Source: American Foundation for the Blind 1980 - 1981 Catalogue of Publications
Available from: American Foundation for the Blind, Publications Department, 15 West 16th Street, New York, New York 10011 Telephone (202) 620-2000

I AGING

PRP012 Robinson, Robert Lee. BLINDED VETERANS OF THE VIETNAM ERA. 1973. 33 pp.
PAP078 Dickman, Irving R. OUTREACH TO THE AGING BLIND: SOME STATEGIES FOR COMMUNITY ACTION. 1977. 168 pp.
PAR031 PROCEEDINGS OF THE RESEARCH CONFERENCE ON GERIATRIC BLINDNESS AND SEVERE VISUAL IMPAIRMENT. 1968. 83 pp.
PRP056 Finestone, Samuel; Lowry, Fern; Whiteman, Martin; and Lukoff, Irving. SOCIAL CASEWORK AND BLINDNESS. 1960. 157 pp.

NEW OUTLOOK FOR THE BLIND AND JOURNAL OF VISUAL IMPAIRMENT AND BLINDNESS

#43. Freedman, Saul Ph.D. "The Assessment of Older Visually Impaired Adults by a Psychologist.
#34. Burnside, Irene R.N., M.S. "A Nurse's Perspective: Blindness in Long-Term Care Facilities. 6 pp.

FAL030 FACTS ABOUT AGING AND BLINDNESS. 1976.
FAL036 Dickman, Irving R. I'M BLIND, LET ME HELP YOU-THE OLDER VISUALLY HANDICAPPED VOLUNTEER. 1974. 20 pp.

II LOW VISION

PLP956 Sloan, Louise L. Ph. D. RECOMMENDED AIDS FOR THE PARTIALLY SIGHTED. 1971. 64 pp.
FLL060 Dickman, Irving R. WHAT CAN WE DO ABOUT LIMITED VISION? 1973 28 pp.

III RECREATION

FIL056 RADIO: AN OLD FRIEND WITH A NEW SERVICE. 1978. 6 pp.
FIL045 RECREATION AND THE BLIND ADULT. 1971. 10 pp.

IV GENERAL

FIL050 THIS IS AFB. 1976. 8 pp.
FIL026 Large Print Volumne. PRODUCTS FOR PEOPLE WITH VISION PROBLEMS. Annual.
PIP080 THE DIRECTORY OF AGENCIES SERVING THE VISUALLY HANDICAPPED IN THE UNITED STATES. 20th Edition. 1978. 448 pp.
FIL061 WHAT DO YOU DO WHEN YOU SEE A BLIND PERSON? (And what don't you do.) 1970. 12 pp.

SAMPLE OF RELEASE OF INFORMATION FORM

I HEREBY AUTHORIZE THE N.H. ASSOCIATION FOR THE BLIND TO RELEASE/OBTAIN MEDICAL/EYE INFORMATION FROM Mr. William Ford.
THIS INFORMATION IS FOR THE PURPOSE OF EVALUATION FOR SERVICES. THIS AUTHORIZATION EXPIRES ON June 30, 1980.

Aug 9, 1979 John Doe

DATE SIGNATURE